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ABSTRACT

The report describes the activities of Model Vision Project, a Tennessee program which diagnosed multiply disabled children and adolescents with visual problems and provided services to those children and their families and workshops and conferences for staff training. The first section provides an overview of the project and descriptions of the diagnostic component, the field services component, the training and evaluation component, job descriptions for each staff position, and populations and area targeted by the project. The second section describes the program goals developed in the planning stages and the means utilized by the project to reach the goals, dissemination and marketing activities, ancillary benefits to parents and other professionals as a result of project activities, and the results of evaluation and validation measures used to monitor and determine project effectiveness. Among appendixes are sample evaluation instruments used with severely handicapped children, sample educational evaluations, job specifications, workshop information, and prevocational activities used in the program. (PHR)

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Final Report

Contract No. 300-75-0307
Project No. 450-AH50018

A Model Center of Programs for Severely Handicapped Children
and Youth with Visual Impairment As One of Their
Primary Handicapping Conditions

BEST COPY AVAILABLE

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INTRODUCTION

The content of this final report of the Model Vision Project (MVP) is presented in a form which serves two purposes: (1) to present an account of the project's activities and success in fulfilling its commitment to the Bureau of Education for the Handicapped and (2) to provide information regarding the project itself, its design and implementation strategies, which may be of interest or help to agencies involved in the delivery of services to the severely handicapped. Two basic concepts are the focal points for this report: what the project was and what the project did.

The first six units of the report comprise the Foundation section or "what the project was". These units include an overview of the project and descriptions of the diagnostic component of the project, the field services component, the training and evaluation component, job descriptions for each staff position, and the population and area targeted by the project. Perusal of these units will provide the reader with information about the structure and scope of the service delivery system developed by MVP.

The following four units comprise the Implementation or "what the project did" section of the report. These units describe the program goals developed in the planning stages and the means utilized by the project to reach these goals, dissemination and marketing activities, ancillary benefits to parents and other professionals as a result of project activities, and the results of evaluation and validation measures used to monitor and determine project effectiveness. Implementation procedures, strategies, and problems are presented in narrative form for purposes of clarity and thoroughness in addressing project accomplishments.

The appendices include information and materials which were felt to be necessary supplements to, or clarification and elaboration of, information presented in the body of the report. Any other materials listed or mentioned are available by request.

FOUNDATION

OVERVIEW OF THE MODEL VISION PROJECT

Implementation of mandatory provisions of education services for all exceptional children and youth of Tennessee has focused community attention on the need for an organized, systematic identification and resolution of problems associated with high risk children. Specifically, a community oriented action program was needed for children and youth that were severely handicapped with visual impairment as one of their primary handicapping conditions. While there had been a trend toward inclusion of visually impaired, severely handicapped children in established residential and day programs, there were, nevertheless, a number of severely multi-impaired children who had remained among those excluded from formal services or were receiving services not individually designed to meet their needs.

An exemplary comprehensive program would be predicated on full utilization of existing resources; expansion, alteration, and coordination of existing programs, as required; and development of new services to account for identified deficiencies in meeting needs of severely handicapped individuals who have a visual problem as a major disability. The Model Vision Project was established upon the premise that appropriate and comprehensive services could be made available to this population through cooperation and coordination of agencies.

It was necessary first to identify the service needs of the population, services available, and service deficits in the community. The age range of the target population was from infancy through 21 years of age, which implied a wide diversity of service needs for the project participants and their families. In the planning stages, the project found sufficient evidence to indicate that educational/training programs for the handicapped are most effective when the "educational" and emotional needs of parents relating to their children are addressed. It was essential that the project provide maximum opportunity for family participation and involvement in project services to the children. Of course, the success of this project would also be highly contingent upon its impact on the educational settings of these children. A wide range of direct and indirect services was considered to be necessary to effect significant changes in the rate of progress of this multihandicapped visually impaired population to be reached by the project.

The Model Vision Project functioned operationally with three service components: diagnostic, field services, and training and evaluation. The diagnostic and field services components provided services directly to the project participants and their families. The diagnostic component provided identification, assessment, and prescriptive services. Parental involvement was a key element in all of these services. Practical limitations (time, personnel, etc.) necessitated the establishment of a priority system for eligibility for the full range of diagnostic services. Direct and/or indirect educational/training services were available to the entire population through the field services component. Parental involvement was integral to the programs of children under school age. Opportunities for parent

education, participation, and counseling were made available to parents of all children participating in the project through the educational programs, home liaison teaching, or social services. The project also provided direct and indirect services to the target population in specialized areas such as orientation and mobility training. Teachers, aides, and technicians received training from the orientation and mobility specialist to ensure continuous appropriate training for the children and youth. Clinical teaching services were provided to these personnel to provide assistance in other aspects of the children's educational programs. The training and evaluation component served the purposes of ensuring that project services were of high quality and monitoring the effectiveness of these services. Individual plans for upgrading staff competencies were implemented through in-service training and tuition waivers for college courses. Another aspect of the training component was that of staff involvement in training other personnel working with the population. This activity was extremely important in the pursuit of the project goal to establish the means for maintenance of services to the population following project termination. Project evaluation was on-going throughout all facets of the project. Child progress data yielded information regarding the effectiveness of project-developed diagnosis, prescription, and implementation techniques. Consumer evaluation of the range of services received provided information regarding the utility and quality of services. Studies of staff time utilization and cost/benefit factors yielded information about efficiency and practicality of the provision of services. Efforts to monitor the project in all areas were ongoing throughout its operation, therefore allowing for revision or alteration of emphasis or procedures as needed. A more complete description of the project components and positions, follows this overview.

In the three years of the project, a total of 127 children and youth were identified as eligible for project services through the screening procedures of the diagnostic component. Fifty-four (54) of these clients received complete initial assessments with prescriptive programs. There were thirty-eight (38) reassessments with updated prescriptive programs. Pre-post test results indicated significant gains across seven developmental domains.

Twenty-seven (27) of the identified MVP participants were served in the three Model Vision Project classes at Harris-Hillman School in the Metropolitan Nashville Schools. Seventeen (17) children and their parents received services through the MVP Infant/Toddler Program. Parents and teachers of MVP participants in other day school classes received home liaison teaching services, clinical teaching services, and assistance with specialized areas of training. Personnel at residential schools and institutions also received training and consultation services from MVP staff.

MVP staff participated in at least ninety-five (95) workshops and conferences for training and dissemination purposes throughout the state and country. Nineteen (19) articles authored by MVP directors and staff have been published in appropriate professional journals.

As a result of MVP efforts, the development of appropriate services for the multihandicapped visually impaired has been expanded. Acceptance of this population by agencies not previously serving this population has been realized. Existing services have been upgraded and made more appropriate and specific to this population. Screening, assessment, and training techniques specific to this population have been demonstrated for and implemented by agencies in the community responsible for maintaining quality services for this population. The subsequent units of this report will further describe the structure and focus of the project and the activities engaged in by the project to reach its goals.

DIAGNOSTIC COMPONENT

The diagnostic component, one of the three major units of the Model Vision Project (MVP), was responsible for developing and implementing a multidisciplinary approach to diagnosing and programming for severely handicapped children with a vision impairment as a primary handicapping condition. In addition to diagnostic services to children, the component was responsible for advisement of parents, professionals, and paraprofessionals on matters related to the continuing assessment of the target population.

The diagnostic team consisted of a core of special educators and psychologists who worked together on a daily basis to carry out the assessments. When medical services were indicated, the team expanded to include ancillary pediatric, orthopedic, ophthalmological personnel and others as needed. The core members were primarily concerned with the educational needs of the child, the family's needs in nurturing the child, and the institution's role in serving the child. The core consisted of two faculty supervisors representing special education and psychology, one full-time educational diagnostician, one half-time family services worker, and one half-time psychological assistant. Practicum students from each discipline actively participated each semester.

The team operated as a well integrated unit because of its fundamental agreement on several basic issues:

- 1) No child is untestable: Every behavior is appropriate to some level of central nervous system functioning.
- 2) The most significant persons in the life of a handicapped child are his primary caregivers. Primary caregivers, usually parents, were included in every aspect of the diagnostic assessment and were supported throughout the assessment by a team member who answered questions and noted areas of concern.
- 3) If changes are to occur through training, primary caregivers are the most likely change agents. Team members demonstrated training and handling techniques to the parents and then supervised them and offered feedback as the parents attempted to replicate the procedures they had observed. Primary caregivers were always encouraged to develop their own methods of training that coincided with the team's recommendations of producing desired changes in the child.
- 4) Effective carryover of the team's recommendations into the community can best be facilitated by the local agent most responsible for the child's educational program. A member

of this local agency was requested to participate in the evaluation of the child in as many sessions as possible.

- 5) If the written prescriptive program is to be functional for the child, it must be functional for the primary caregivers and the teacher responsible for implementing the program. The written evaluations clearly described procedures and instruments employed during the assessment, results obtained from the procedures, the implications of the results for educational programming, and recommendations for effecting changes in the home as well as in the classroom.
- 6) The team's evaluation methods continually underwent rigorous evaluation: Parents were asked to respond to the effectiveness of the services, teachers evaluated the effectiveness of the prescriptive program, children's behavioral changes were evaluated through a tracking form, and the team reviewed its own work and its service strategies based on the feedback received. Consumer evaluation of diagnostic services in the first year yielded a rating of 4.68 on a 0-5.0 scale. A survey of parents at the end of the third year yielded a rating of 2.76 on a 0-3.0 scale.

A detailed description of the diagnostic process follows this section.

Diagnostic personnel were also available to teachers and parents of the population for assistance with revisions of educational prescriptions as necessary. In this capacity the diagnostic staff had many opportunities to observe children in their classrooms which provided them with additional information about progress toward and appropriateness of prescriptive objectives.

Additional services of this component included the training of diagnostic and evaluation personnel who might provide services to the target population at a later time and to individuals employed in other settings working with similar children. Through conference presentations, workshops, and consultations, diagnostic personnel stimulated awareness of effective methods of assessing the multihandicapped on local, regional, and national levels. Staff members participated in workshops and presentations throughout the country in the three years of the project. Other dissemination activities have included the publication of journal articles, preparation of other manuscripts, and research directed toward the development of assessment procedures.

**Diagnostic Process:
Identification, Screening, Diagnosis, and Prescription**

The initial service goal of the diagnostic and evaluation component was to bring to the attention of the project staff those children between the ages of birth up to, but not including those 22 years of age, who possess a serious visual impairment complicated by at least one additional handicapping condition--the combination of which renders the child severely handicapped. Initial screening goals were to determine eligibility for full evaluation and to assess informally the child's development in specified areas, to determine urgency of full evaluation. A comprehensive assessment of the child's skills and development followed. Data were reconciled with psychological and/or auxiliary medical evaluation findings.

Developmental/educational prescriptions were prepared, specifying objectives and procedures to be used in realizing them. This total child care plan was negotiated between clinical team members, staff of prospective program service centers, and the child's family. A flow chart depicting the diagnostic process follows this narrative description. (See Figure 1.)

Identification of Severely Handicapped Children with Visual Impairment

Purpose. The identification process sought to locate those children between birth and 22 years of age who are severely handicapped with visual impairment as one of their primary handicapping conditions. The counties of Tennessee covered in this search include the following: Cheatham, Davidson, Dickson, Robertson, Rutherford, Sumner, Williamson, and Wilson.

Personnel. The identification process was carried out by graduate students employed on a part-time basis by the project and involved sending letters, reading referral forms, and making telephone contacts.

Procedure. Referral letters, return envelopes, and five referral forms were sent to agencies in the area who were likely to have knowledge of the target population. The Nashville Academy of Medicine and Davidson County Medical Society were contacted by telephone to obtain a list of pediatricians and ophthalmologists in the Nashville area. These individuals also received the standard letter and forms. Two weeks after the information was sent, each agency was contacted personally by telephone to see if there were any questions or if more referral forms were needed.

When the referral forms were returned they were checked as follows: (a) Individual must be under 22 years of age, (b) Individual must have visual impairment as a primary handicap, (c) Individual must show evidence of one or more additional impairments. (Children who had previously been identified as deaf-blind were not eligible for this program.)

If the individual met the conditions for placement into the program, s/he was then placed on the screening list. If the individual did not meet the qualifications, a letter of explanation was sent to the referral agency, but the referral form was retained with other inappropriate referrals.

Product. The product of this identification process was a list of those individuals who were suitable for screening and the referral agency through which they could be contacted.

Screening of Severely Handicapped Children with Visual Impairment

Purpose. The screening process determined the general educational and service needs and established the priority of one case over the other according to the needs of the home and the child. More specifically, through home screening the support for a home-based program was evaluated. Screening of the child also indicated the need for a more extensive evaluation subsequent to the child's placement in an appropriate program.

Personnel. The diagnostic coordinator prepared the home visitors (a) in parent reactions during specific stress periods and (b) in screening procedures and instruments. Following the completion of a screening, the diagnostic coordinator reviewed each case and decided on the qualifications of the case for project services, the urgency of the case for services, and possible placement of the child.

Procedure. The procedures for the initial screening of the child and evaluation of the home as a support system for in-home stimulation and training programs consisted of conducting a home evaluation and administering general screening and visual screening instruments to the child who had been identified as a possible candidate for the programs. The entire screening procedure was designed to be completed in approximately two hours. As the screening interview could have been one of the parents' first confrontations with their child's problem, the home evaluation was designed as an informal procedure and allowed the home visitor to answer many items either from referral records or by listening to the parent.

Product. The product of the screening process was a Screening Information Report on each child seen by the home visitors. The report included the following: the Denver Developmental Screening Test or an appropriate general screening form for higher functioning children; a home evaluation record; an informal visual screening checklist; and a release of information form. The diagnostic coordinator made placement and service decisions based on this product.

Diagnostic Assessment of Severely Handicapped Children with Visual Impairment

Purpose. The diagnostic assessment stage was necessary to more specifically assess potential needs and the learning style of the visually impaired severely handicapped person as a basis for future programming, eventual placement, and referral recommendations. Emphasis was placed on the process variables or modes of functioning styles through quantitative and qualitative analysis of tasks and the functioning levels of development in the individual.

Personnel. The diagnostic coordinator and educational diagnostician were responsible for the diagnostic assessment. They were sometimes assisted in the educational assessment by graduate students in the Department of Special Education who indicated a special interest in the assessment of multi-impaired children. These students were given specific responsibilities in the assessment process and were directly supervised by the diagnostic coordinator, diagnostic supervisor, and educational diagnostician.

A clinical psychologist of the Child Study Center was responsible for the psychological assessment. Working under the psychologist were two graduate students employed to participate in this project. One student was directly responsible for testing while the other was responsible for parent interviews and counseling.

The following specialists were available on a consultant basis: pediatrician, cardiologist, orthopedist, ophthalmologist, otologist, neurologist, audiologist, neuropsychologist, and any other necessary consultant. These consultants were a part of the Child Study Center Consultant Staff and were available through the Vanderbilt University Hospital and Clinic or on a private basis if needed.

Procedure. Upon referral by the screening component of the project, the child's parents received an application for diagnostic assessment. Completed applications and additional requested information were reviewed by the diagnostic coordinator. An assessment schedule was designed based on the individual's needs. A representative of each child's local educational agency was invited to participate in the assessment of the child. Content descriptions of the procedure of the major assessment components follows:

The parent intake interview was conducted by a parent liaison worker for the purpose of gathering information essential to the diagnostic process. It included a family history, a review of the current family milieu, an overview of how the client fit into his home environment, the impressions of the child as seen by the parents, and statements by the parents of their needs in relation to their child. Contact between the parent liaison worker and the family was daily during the week of assessment; however, more formal interviews were limited to one or two sessions.

The focus of this entire project was on educational services to severely handicapped children with visual impairments. For this reason, it was essential that a major portion of the diagnostic services center on needs related to educational skills. In the educational assessment the individual was observed via formal and informal assessment procedures in the area of cognitive/adaptive behavior, language behavior, motor behavior, social-emotional behavior, and self-care behavior. Through cognitive/adaptive assessment the child's strengths and weaknesses in performing tasks related to classroom learning experiences were targeted. The child's initial proficiency at specific tasks was observed, and short-range intervention strategies were simulated so as to gain information about the child's preferred learning modalities, material and procedure effectiveness, and rate of behavioral range. The parents observed the entire process and then were trained in those procedures found to be most effective.

Through the language assessment the child's inner receptive and expressive language abilities as well as speech and articulation proficiency were determined.

The motor assessment included fine- and gross-motor assessment of developmental functioning levels and perceptual abilities. Due to the importance of mobility in the life of a severely handicapped individual with a visual impairment, particular emphasis was placed on this aspect of the assessment. Funding for research in this area was awarded to the principal investigator, Dr. Randall Harley, during operation of this project. MVP was able to take immediate advantage of this investigation.

The child's relationship to himself, his peers, his family, and his community was considered in the social and emotional assessment. The proximity of the Child Study Center to the John F. Kennedy Experimental School afforded ample opportunity to view the child in settings with other children as one would find in a classroom or school environment. With the family as participants in the entire evaluation process, the staff was able to continually assess the child as a family participant.

The self-care assessment is an important component in the comprehensive evaluation of any handicapped child, therefore levels of independence in daily living skills were assessed.

Psychological assessment included format testing using carefully selected standardized tests, adaptations of tests for various handicaps, and informal testing using instruments expressly designed by this population.

Depending on the age and ability level of the individual, assessment of vocational potential was also included.

The assessment procedures required three to five days and took place at the Child Study Center and, in cases where the child was already enrolled in a formal program, in the child's major educational environment as well. Applicants were seen at the rate of approximately three

cases a month. Reassessments were scheduled for many of the clients 12 to 18 months following initial assessment. Original prescriptions were revised and updated as necessary.

The following is a list of the various screening and assessment instruments used and recommended by the diagnostic team for use with visually handicapped children and youth. (See packet describing instruments in Appendix A.)

Screening Instruments

Vision - New York Flashcard
Vision Test
Functional Vision Inventory

Developmental - Developmental Activities
Screening Inventory (DASI)
Denver Developmental
Screening Test

Psychological Instruments

Infant Intelligence Test (Cattell)
Stanford-Binet Intelligence Test,
Form L-M
Bayley Scales of Infant Development

Developmental Assessment Instruments

Motor - Stanford Functional
Developmental Assessment
Bayley Scales of Motor Development
Peabody Developmental Motor Scales

Language - Sequenced Inventory of
Communication Development
Environmental Pre-Language Battery/
Environmental Pre-Language Inventory
Receptive-Expressive Emergent
Language Scale
Preschool Language Scale

Cognitive/
Adaptive - Ordinal Scales of Infant Development
Cattell Infant Intelligence Scale
McCarthy Scales of Children's Abilities
Detroit Test of Learning Aptitudes
Merrill-Palmer Scale of Mental Tests
Haussermann's Developmental
Potential for Preschool Children

Social/
Self-Help - Lakeland Village Adaptive Behavior Scale
Social Maturity Scale for Preschool
Blind (Maxfield-Bucholz)

Product. Results of the assessment were presented in two ways. An oral report of findings by staff members was shared in a feedback session with the parents on the final day of the assessment. At this time, the parents and community workers had ample opportunity to ask any further questions regarding the findings. The major product was a comprehensive written report covering all phases of the assessment, both those detailed above and assessments of auxiliary consultants participating in the particular case. (See example of an evaluation report in Appendix A.)

IV. Prescription for Severely Handicapped Children with Visual Impairment

Purpose. Prescriptive programming was included in each report to assist caregivers and teachers in utilizing assessment information to move the child from the current level of development to the next. The prescription precisely defined the goals and objectives for each area and level of the child's development and detailed the program for obtaining the objectives.

Personnel. The prescription was written by the diagnostician, the members of the educational staff, the child's local educational agent, and the parents.

Procedure. In the final days of the diagnostic process, the diagnostic coordinator convened the personnel involved and discussed the prescriptive needs of the child. The parents and local educational agents provided information as to materials and personnel to carry out the prescription. The prescription was generated from the diagnostic findings.

Product. The product was a detailed plan for individual instructional services. The prescriptive plan was summarized orally at the final staff meeting and written in detail in the comprehensive assessment report. Copies were made available to persons designated by the parents as recipients.

(See the table on page 90 in the Program Evaluation section for a breakdown of diagnostic staff time utilization per assessment.)

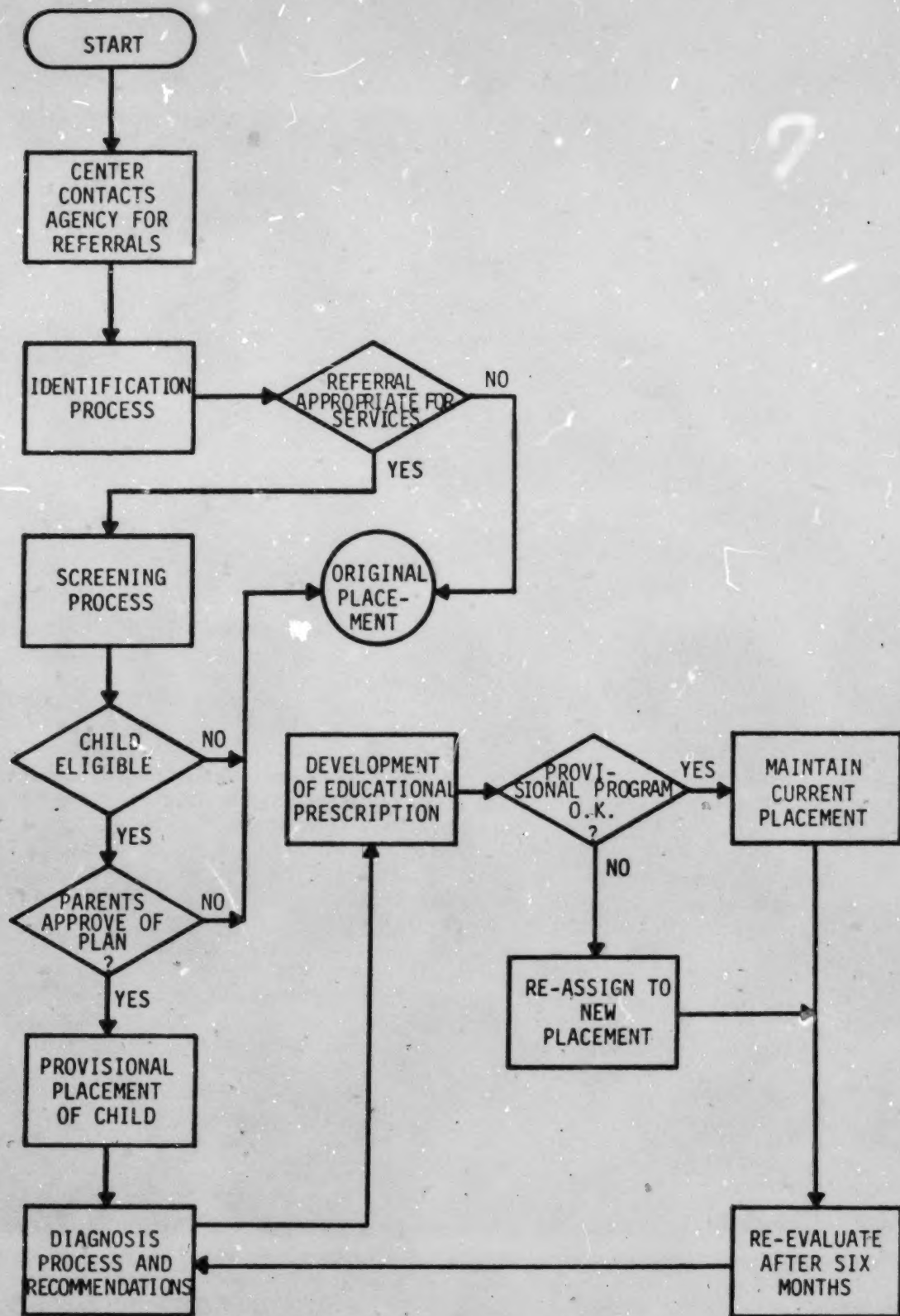


Figure 1 21

FIELD SERVICES: ENROLLMENT AND MATRICULATION

The goals of this component have been to expand, enrich, support, and investigate if necessary, community-based programs which would serve the identified target population. As these programs were identified, a network for cross-communication was established or strengthened for maintenance of quality service to clients over a long period of time.

Existing Services

The design of the field program for a model community-based program was predicated on the conceptual model described in this report. The advantage of such a model laid primarily in promoting a comprehensive system which incorporated prevailing service, but which was not merely a composite of it.

The range of services, a system of priorities for program development, and functional criteria for measuring adequacy were developed on the basis of a model view in which all necessary services were enumerated, and against which current services could be compared. The existing system was found wanting.

Each respective element was in itself relatively effective, though administration cited needs and omissions in relation to their respective goals. Principal deficiencies became evident through a process of comparison between what existed and what was needed to effect minimal services.

The full magnitude of need growing out of a community desire to offer fully adequate, comprehensive services was only evident when glaring deficiencies and qualitative limitations in existing services were combined. In short, many services were provided, but were fragmentary and below the level of expectation of those providing the services: Many voids were revealed when these established services were contrasted with an ideal model.

Available services were, in fact, substantial: Ideal services would be approximated if each were afforded resources to expand, enrich, support, or initiate change as required. Field sites' services are described below as they were at the inception of the project. Many activities engaged in by MVP in the three years to achieve the original 12 goals were designed for cooperative assistance between MVP and agency in filling gaps in service delivery.

Clover Bottom Developmental Center. Clover Bottom Developmental Center, Donelson, Tennessee, is a residential and training

facility serving mentally retarded persons from the 40-county area of Middle Tennessee. The resident program serves 972 clients. The facility develops and coordinates community programs in the Middle Tennessee area currently serving an additional 1,000 mentally retarded persons. The physical setting lies within the suburb of Donelson, a 15-minute drive from the project center.

Programs in operation include the following: a multidisciplinary diagnosis plan; a structured admission board with careful attention to due process; psychological and social service programs through cooperative plans with nearby institutions of higher education - particularly Peabody faculty and students; a family training and respite care facility; outpatient evaluation services; a Diagnostic and Evaluation Center, and a Community Evaluation Center.

Among the resident population of 972, 237 individuals between ages of 3 and 21 years are considered severely or profoundly retarded. Approximately one third of the entire resident population is multihandicapped.

Of the total population, 107 or more than one tenth of the entire population were identified as visually handicapped, blind, or deaf-blind. Forty-two were within the age range of our target population. There are no residents between the ages of 0 to 2 years.

Within the 3-year to 21-years age group, 20 nonambulatory clients served in the Total Care Division, Clement Research Station were seriously visually impaired. Three were receiving some individualized pre-academic training. All others were participants in newly established on-ward language stimulation program. All were participating in feeding and toileting self-care programs.

Fifteen ambulatory clients among the target population resided in Adams Hall, a separate facility for multi-impaired blind. Of these, five attended the community services school program, a combined resident/community education program in the Clover Bottom campus. Two others, older and further developed, were accommodated in the Human Development School, the second major education program in the Clover Bottom campus; eight most severely handicapped blind were receiving individualized tutoring and structured small group activities under the direction of a qualified teacher certified to serve both the visually handicapped and the retarded. Four residents from young-adult residences were also served in the Human Development School.

Three nonresidents from among the target population were transported daily to attend the Community Services School Program. Two spent the entire school day; one was on a modified day program.

Altogether, 42 individuals were within the age range. Each was engaged in some structured activity. The formal services were varied, serving residential and community children and youth, accommodating nonambulatory and ambulatory, conducting programs at several levels to accommodate chronologic age differences and all with varying degrees of

intensity. On the whole, the range of services was broad. The qualitative aspects of the program, however, failed to meet Clover Bottom staff criteria. Services were fragmentary, and somewhat cursory. The staff needed technical information on methods, curriculum, behavioral management, selection of appropriate materials, and mobility. Team teaching characterized the two principal education programs on the Clover Bottom campus. Six satellite programs in residence halls were self-contained. Among 17 certified special educators and 9 teacher aides, only 2 had formalized training with respect to severe visual disability.

Three critical service needs at Clover Bottom were identified: 1) to mount an intensive specialized in-service program; 2) to hire a full time mobility instructor; and 3) to employ an additional teacher in the Adams Hall residence to double the amount of direct instructional services currently afforded.

Tennessee School for the Blind. The Tennessee School for the Blind is located in Donelson, Tennessee. As the principal residential resource for visually impaired children in the state, it currently serves 175 youngsters. The curriculum is a combination of two tracks: A traditional academic stream leads to high school diplomas; a growing alternative is a track for multi-impaired students who require emphasis on skills of daily living, concept development, motor development, and sensory awareness. This multi-impaired track accommodates 35 students at this time. Enrollment in this area was expected to increase. Curriculum development projects were contemplated. MVP would be asked to confer with school authorities in this regard.

In 1973, two separate classes in a new primary facility were organized to accommodate deaf-blind children. There are two teachers, two aides, and two houseparents serving eight deaf-blind children between the ages of five and nine.

No specialized residential program was currently available at the School for the Blind for the target population between ages of 4 and 7. A new service with two service components was proposed. Four children whose programs require a residential orientation were to be served formally. In addition, the classroom would accommodate as many as two additional children, placed there temporarily when a preliminary evaluation of the home indicated a need for child/family separation and while awaiting a comprehensive diagnosis and assessment from the project center diagnosis and assessment component.

Physical space for the new class was assured. The primary level residence could absorb another group of young multi-impaired children; the administrators were prepared to assist the project in implementing the residential program, as required.

Metropolitan Public Schools Department of Special Education. The Special Education department of the Metropolitan Public Schools of Nashville provides varying services for visually impaired students. Four itinerant teachers, each with a caseload of approximately 14 students,

consulted with regular classroom teachers upon request. There was a resource teacher for kindergarten through fourth grade students who are mainstreamed at Berry School; their schedule of time in the resource room varies according to individual needs of the children. An itinerant teacher served fifth and sixth grades at Head School.

At the junior high level, a resource-itinerant teacher provided educational services at Litton Junior High School. At the time, high school students were served by the four itinerant teachers. However, because of the changing population of younger visually impaired children who often have additional disabilities, a need for a more specialized high school education service was projected for the near future.

At the time, two self-contained classes for our specific target population children at Cavert School and the Peabody Kennedy Center provide educational services for visually impaired children who could not be mainstreamed because of concomitant disabilities.

The Hillman School (Harris-Hillman) was a new modular special education facility which opened in the fall of 1975. The demonstration class within the Experimental School of the Mental Retardation Laboratory of the Kennedy Center was to be moved into the new Hillman facility. In 1973-74 and 1975-76, this classroom was operated jointly by Metro schools and Peabody College. As of 1975-76, the entire program was to be supported and housed by them. Likewise, existing classes at Cavert would be transferred. Within these two classes seven children qualified as being a part of the target population of the proposed center.

Nashville Regional Office, State Services for the Blind Division.

The local office of State Services for the Blind maintains both regional personnel and state personnel. The regional personnel consisted of nine persons who provided vocational rehabilitation services, parent/home counseling of families of blind children, and a home teaching program. In addition, business enterprise counseling was offered. There were five full time rehabilitation counselors; two others served as rehabilitation teachers; the final two functioned as business enterprise counselors. Liaison between the Nashville Regional Office, Metropolitan Nashville/Davidson County Schools, and the Tennessee School for the Blind was assigned to one additional counselor physically stationed on the premises of the Tennessee School for the Blind in Donelson.

While Federal guidelines restricted service to those 16 years of age and above, with certain prerehabilitation services extended to those as young as 14 years of age, the state level enabling statute authorized rehabilitation workers on state funded programs to serve clients of any age. A state network of 10 such home teachers included 2 assigned to the Nashville office.

Home teachers coordinated family/community services on behalf of young blind children. Services included parent counseling, provision of pertinent literature, help in identifying resources for diagnoses and assessment and educational planning and implementation. Home teachers conducted in-service training programs for health, welfare, and general

educational personnel on the local level. They articulated individualized service plans with established child oriented programs of other state, local, and private agencies. Parental contacts were maintained.

At the time, more than 75 sets of parents of visually handicapped children were known to the two home teachers working within the area to be served by the project center. It was estimated that more than one-third were parents of severely multihandicapped children. The parents had organized into a mutual support group. They were oriented toward development of a crisis intervention, 24-hour hotline program, and to provide social outlets among families with similar circumstances. They were not a social-action oriented group.

Budgetary constraints and limited resources presented some problems in terms of expansion of services. In an effort to circumvent these problems, the MVP proposed to add one full time qualified community liaison worker with emphasis on children from one to three years of age to complement the current staff by adding expertise in the area of the multi-impaired. This specialist would assist in the development of an organized parent information/education plan, to participate and/or organize and conduct in-service orientation programs; and to liaise with families and serve as a catalyst in effecting rapid, functional ties between families in need and agencies that can assist.

Peripheral Service Programs. Peripheral programs in Nashville/Davidson County had accepted or served severely handicapped multi-impaired children with a visual disability in the past and expressed willingness to do so again in the future.

The Regional Intervention Program (RIP) provided information, referral, and treatment services to families of handicapped children under the age of 60 months in the 26-county area served by Central State Psychiatric Hospital. The program functions to prevent or significantly delay the institutionalization of developmentally-delayed, autistic, or severely behaviorally disordered children under five years of age. To achieve this goal, parents of referred children participate daily under the supervision of a small professional staff in implementing programs of child management, language training, and preschool services for their own children. Liaison services in the form of follow-up, placement, consultation, and intervention services are provided for all participant families.

Walden House is a residential day school program for children through 12 years of age whose primary problem has been identified as a behavior disorder. Children with visual impairments have been accepted although a syndrome of mental retardation disqualifies children.

The staff of Walden House includes a director, assistant director, 6 professional consultants, 2 research assistants, and 16 behavior technicians. They indicated a desire to cooperate with the project by consulting with staff or offering a trade-off condition, (i.e.,

providing half day educational services for a project child in order to buy services at Hillman School for their own students).

The Child Intervention Program (CIP) serves children of elementary school age (from 5 to 12 years of age) who have been referred because of serious social and academic problems. Referrals are made by local mental health centers only when the child's problems are so severe that the community treatment agency determines a need for adjunctive resources. CIP requires that the parents commit their time and energies to their own child's programming and to the training of other parents. The program has a small staff of special educators, child development consultants, and parents. Services offered range from teaching the parents to work with their children to providing liaison services to mobilize community resources in behalf of the child and family. Referrals are made by the Child and Youth staff of the mental health centers in the Middle Tennessee regions.

New Services Planned and Developed

Infant/Toddler Program

Infant/Toddler Program. The infant/toddler program, jointly supported by the Project and the Experimental School of the John F. Kennedy Center at Peabody College, provided services to children through their parents. Parent and child attended together, and an early childhood specialist served as the resource to the parent for information about child development, behavior management, and strategies for providing opportunities for the child to learn. The classes were small, allowing for more informal, personal interaction between parents (an internal support system). Counseling services were available to all families to assist them in dealing with the unique needs of their children. The specialist did not serve as the children's teacher; the parents assumed that role with guidance from the specialist.

Parents were expected to serve as active agents in the education of their children. The parents and the specialist together designed a plan delineating a schedule of home-school contacts, with a minimum of two contacts per month. These contacts provided information to the parents on appropriate guidance and instructional methods that would best facilitate the growth and development of their child.

Various options were open to the parents. Any or all of the following were strongly recommended by project staff.

For parents of infants:

1. Weekly or twice monthly classroom visitation and in-class work with either the parents' own or other children, followed by after-class discussions concerning topics such as materials, methods, behavior management, and data collection. Parents had the option of making as many as 2 classroom visits weekly.

2. Evening home visitations by the teacher or home liaison teacher who could demonstrate the use of appropriate materials; discuss the child's progress in home programs; and explain data collection systems, behavioral control techniques, etc.

Formal and informal parent training was provided to enhance parent abilities to implement each child's prescriptive program. The specialist modelled techniques for the parents with their children but primarily provided feedback to the parents about their own effectiveness with the children, reinforcing all positive aspects. Given the opportunity to work with children other than their own, the parents were provided with a broader range of experience with children functioning at different levels with different types and degrees of handicapping conditions. There was a dual purpose served in the utilization of practicum students from special education programs: (1) providing more individual educational instruction to the children and parents and (2) providing students in training the opportunity to work with the multihandicapped infants and their parents.

Scheduling and educational programming was highly individualized as related to child and parent needs. The curricula were Piagetian-based, drawn from such guides as the Wabash Guide to Early Developmental Training and a sensori-motor curriculum guide devised by Geseila Chatellant. Child by child objectives were similar in that each reflected emphasis on the sensori-motor stage of development. In planning activities to meet these objectives, a strong emphasis was placed on the integration of all areas of development (language, motor, social/self-help, cognitive/adaptive) in single activities. Handling, carrying, and positioning techniques were used to inhibit primitive reflex patterns of movement and to facilitate more normal movement and performance.

A materials library was initiated and partially equipped with special material from the American Printing House for the Blind. Parents signed out materials (instructional and reading) for use in the home, thus directly implementing some elements of the classroom curriculum in the home.

A total of 17 infants and toddlers have been served in this program through the three years of the project. As federal law does not mandate that children under the age of 4 years be served by the public school system, placement for the children under 4 following MVP termination was sought in other programs. As of June 30, only 2 children had not been definitely placed in an educational program.

To facilitate provision of services by others to this population in other settings, the early childhood specialist and diagnostic coordinator developed a curriculum for multihandicapped visually impaired infants. The specialist has also developed a guide for working with parents of multihandicapped visually impaired infants in a classroom setting. These products are ready for dissemination and copies have already been distributed to practitioners and interested others in the field.

The early childhood specialist was also involved in workshop and inservice training activities during the three years of the project. (See Dissemination and Marketing Activities section of this report.) She worked (on a consultative basis) with other programs where MVP children had been accepted.

Public Day School Program. Three classrooms - primary, secondary, and prevocational - were supported by the Metropolitan Nashville Schools' Special Education Department. The classroom teachers were certified in the education of the multiply impaired and had a strong diagnostic/prescriptive teaching orientation along developmental lines. In each class, one teacher with a classroom-aide formed the core of the instructional staff, with supplemental support personnel including home liaison teachers, an orientation and mobility specialist, an orientation and mobility technician, a clinical teacher, a physical therapist, a speech therapist, an occupational therapist, a social worker, a job placement counselor, available when necessary.

The classes were developmentally oriented with the primary focus on generalization of concept-learning across materials and tasks. Individualized programming was generated to address gaps in each child's development and provided a solid conceptual base for advancement to higher level skills. Activities were designed with a high probability for success to maintain motivation. Due to the unique needs of a population who function at infantile levels but who are chronologically older, a variety of teacher-made materials was found in these classrooms.

A unique function was served by the classes in that the population's needs required adaptation of available curriculum guides for effective use in training due to the multiplicity of handicaps with the common visual handicap. The curricula and the prescriptive educational programming information available for each child through the assessment procedures provided the bases for implementation of individually appropriate educational services.

An important aspect of the provision of educational services unique to this population is developing and maximizing functional use of residual vision through vision training. The vision screening measures used by the project provide information about each child's present use of residual vision. The three basic visual behaviors targeted for training are focusing, tracking, and scanning. Activities on any developmental level in any area of development can be designed to encourage these visual behaviors. Visual training is not considered a separate function in the education of these children but was integrated into gross motor activities, cognitive/adaptive activities, etc. Children on higher developmental levels were provided specific training in orientation and mobility skills in which functional vision should be utilized to a maximum. They received training in sighted guide, pre-cane, and cane techniques, according to the individual levels of readiness.

Prevocational skills were introduced at the primary level in terms of using functional materials encountered in daily living to teach early developmental concepts. Prevocational training was

ongoing in all classrooms in focusing attention on maximal independence in living and future work activities. Knowledge of the child's general functioning level and his/her ability to comprehend language, attend to a task, manipulate materials, and cooperate and maintain self control in social situations - knowledge generated by the diagnostic component provided the teacher with a sound basis for determining the child's prevocational skills and readiness to participate in work activities. In the prevocational classroom, specific pre-work activities were part of the daily classroom activity. Students with good prerequisite fine motor coordination were taught to assemble two and three piece nut and bolt assemblies. A few students in the class worked on stapling, collating, and fitting correctly folded paper into business envelopes. All students worked on developing sorting skills since this is one universal measure of vocational readiness used by all agencies involved with the handicapped. Behaviors required for successful integration into a work setting, such as adequate attention span, work set, and consistent on-task behavior, were emphasized throughout all formal activities.

As functioning levels of many of the students indicate, curricular activities in the primary and secondary classes focused primarily on early cognitive/adaptive skill development and self help acquisition. Many target skills focused on learning through the tactile kinesthetic modality since many of the students in the class possessed minimal or no residual vision. For example, sorting and matching skills were taught using concrete objects and tactually differentiated materials. Additional skills stressed in the secondary unit were directionality and laterality concepts. These skills are the building blocks for writing, mobility and orientation skills, and numerous prevocational tasks. They are especially critical for visually impaired students since they must depend on understanding verbal directions to function in their environment. Beginning number concepts were taught by initially stressing the acquisition of one to one correspondence skills, which was taught in a number of ways incorporating daily living skills whenever possible.

Social/affective development was stressed in the young adult/prevocational unit, and activities were planned to enhance development of affective skills. The older, more mature students took part in a regularly scheduled group interaction where the teacher acted as discussion leader and facilitator in modeling and reinforcing socially desirable behaviors. Community-based activities were planned to provide students with normalizing experiences. Peer-tutoring relationships were encouraged to develop social interaction skills and improve self-concept.

Parent involvement in these classes was not so extensive as in the Infant/Toddler Program. Parents were invited to volunteer in their children's classes as aides, and several parents participated in this capacity. In IEP conferences parents participated in developing the objectives for their child. Through school/home communication, parents received information about their child's progress toward objectives

and information to assist them in facilitating home programs. A parent group was organized and met monthly. Through participation in this group, parents had the opportunity to interact with each other and become active in advocating for their children's futures. All parents received materials and information distributed by the home liaison office of MVP. The home liaison office also served in a referral and information capacity to parents and teachers.

A total of 27 students were served in these three classes during the three years of the project. MVP staff and teachers were extensively involved in locating and preparing the future appropriate placement for these students.

Eleven (11) MVP clients were served in other classes for multi-handicapped at Harris-Hillman. The project has worked in cooperation with Project Change, a project serving the severely and profoundly retarded, to establish a joint parent group.

Field Services Component Activities

Tennessee School for the Blind. The MVP has functioned in a catalytic role as a contributor to the climate in which the school has found it possible to expand its services. Special staff and faculty training projects calculated to broaden the base of acceptance and to provide specific techniques for use with the target population were conducted. The school's response to the challenge brought about conditions that made it possible to expand and formalize offerings for increasingly complex blind children.

Clover Bottom Developmental Center. New services and alterations modeled by the MVP staff for the staff at Clover Bottom have included: identification of visually impaired children through a structured referral and screening process; direct and indirect clinical teaching services; orientation and mobility services; and a structured series of in-service training workshops on the technical aspects of serving visually impaired mentally retarded persons,

At least one third of the students in the MVP classrooms at Harris-Hillman came from Clover Bottom. This precedent of partial de-institutionalization has been maintained as at least 10 more Clover Bottom residents have been placed in this public school facility.

A major accomplishment has been the addition of an intermediate level mobility technician. Through the industry and productivity of the project staff, the administrators began to recognize the need for continuing, intensive service, particularly in the area of orientation and mobility. The project recommendation for a full-time employee to provide O & M service was easily defended in terms of general institutional needs. A large problem was defined; it was shown that a program which resulted in gains for children would also enhance the program for adults. The MVP was invited to assist in: the recruitment and

selection of an employee; the development of job specifications; and provisions for a direct on-site training program for the individual selected. Once implemented, the overall plan--with a new, full-time O & M technician-- quadrupled the numbers directly served, and with anticipated ripple will produce far reaching interjection of orientation and mobility concepts, of attitudes, and elevated learning expectations for individual students.

Social Work Services. The role of the social worker in the project was predicated on a generic family casework orientation designed to assist families of the target population with general management of home/community problems. However, the role developed into a more broadly based social service liaison program. Social service activities consisted of: resource identification; case study reviews, as available; teacher interviews; and, individual agency contacts in order to effect liaison with agencies broadly charged with service obligations to children and their families within the target population.

Social work activities moved toward interagency liaison with crisis intervention as the primary direct service activity. Through liaison work, the social worker modeled a specialized role to demonstrate the need for continued service under community agency and institutional auspices.

Vocational Training/Placement Program. The vocational specialist/placement counselor was responsible for providing information to project clients and parents concerning vocational rehabilitation and placement services. Activities were centered around data collection through site visits and community-wide interpretive contacts. The purpose was to identify: available vocational placement and training resources; prevocational skill attributes; and, teaching/learning experiences that would contribute to building a functional relationship between young adult classroom programs and public/private rehabilitation offerings.

TRAINING AND EVALUATION COMPONENT

Training Component

The training component of the Model Vision Project has had two major focuses: (1) training of project staff to upgrade and supplement the competencies of the staff and (2) training of personnel involved in the delivery of services to the target population in other agencies to upgrade and supplement the services they are providing. Most of the project personnel were hired because of competencies previously attained in working with the severely handicapped or visually impaired or experience in their areas of service delivery. Staff members were very competent in many specialized areas, but there were competency areas in which individual staff felt they needed development in order to perform effectively in their jobs.

At the beginning of the project, each staff member assessed his or her own competencies and, jointly with the project coordinator, planned a program to fit his or her needs. Training and development were obtained primarily through two avenues: (1) Tuition waivers were available to the staff members to add needed competencies through college courses in special education, and (2) an inservice program was designed as a series of workshops and regularly scheduled meetings. During the first two years of the project when direct services were emphasized, staff development efforts were extensive. In the third year when direct services were being phased out, it was not felt that staff development should continue to be a primary concern. Through the advice of consultants, and support of the Advisory Council, the project staff decided that the long term objectives of training key leadership personnel in the community would result in a greater impact on the target population.

One of the primary aspects of each staff member's job was that of developing materials and providing training related to working with the multihandicapped visually impaired and their families to other personnel working with MVP participants and similar populations. The clinical teacher, mobility specialist, home liaison teacher, and social worker provided formal and informal training and assistance to teachers, parents, houseparents, aides and others who were working with the target population in the catchment area. The primary purpose was to acquaint these people with the specialized skills and techniques necessary for working with the multihandicapped visually impaired.

Home Liaison Teaching. Parents, teachers, and agency personnel working with severely handicapped children with visual impairment have required assistance in setting up coordinated educational intervention programs suited to the needs of each child, and in gathering information about project services and availability of special assistance from state and local agencies. These coordinating services have been provided by the Project primarily through the home liaison teachers.

The home liaison teachers were responsible for a number of services, both family-oriented and community-oriented:

1. intake interviews with parents,
2. screening referred children for eligibility,
3. liaison between classroom and home,
4. assistance to families with home training programs,
5. location of appropriate services for "problem placement" children,
6. liaison between project and community agencies on behalf of clients and teachers,
7. gathering and distribution of parent education materials,
8. arranging workshop training for agencies developing or expanding services for multihandicapped, and
9. preparing and presenting workshops.

Clinical Teaching. Services provided by the clinical teacher included parent training, instruction of individual students, teacher training, paraprofessional training and consultation with teachers. The preparation of training packets and instructional materials on high interest/high need areas was also a part of the clinical teaching role. Training materials were utilized in workshops and were shared with interested professionals as a project dissemination activity.

Planning for staff development was also a responsibility of the clinical teacher. Resources for inservice training were investigated and contacted as a result of staff self-assessment of competencies. Individual requests for training were made to the clinical teacher. Inservice training was evaluated by the staff as part of the project's commitment to evaluation of its effectiveness.

Orientation and Mobility Services. The mobility instruction was conducted by a full-time staff mobility specialist, focusing on four areas of service: instruction of individual students, consultation with teachers, paraprofessional training, and the training of an orientation and mobility technician at Clover Bottom and at Harris-Hillman School.

The role of the orientation and mobility specialist included provisions for a full range of transitional direct orientation and mobility instruction such as use of a sighted guide and pre-cane techniques, as well as the development of specialized orientation and mobility techniques and procedures for the training of severely multiply handicapped blind children. Indirect service responsibilities included overseeing the teaching of pre-cane mobility skills and concepts by special classroom teachers and involved paraprofessionals, the development of a functional system of mobility consultation to the diagnostic and training segments of the program, and the development and field testing of a structured, systematic series of in-service training workshops. Multi-media training materials were developed by the O & M specialist and are ready for dissemination.

Training Effectiveness. The evaluation of the effectiveness of MVP training activities emphasized the validation of staff-developed training modules for use by parents, paraprofessionals, and community agency personnel. Module validation was based on the pre-post module performance

of trainees on criterion reference tests. These performance data were analyzed using traditional statistical significance tests to document observed post-training improvements in module participants. (See the Project Evaluation section of this report for evaluation results)

Cooperation with Innovative Training Grant. Graduate students at Peabody College receiving training in the area of the multihandicapped received practicum experience through the Model Vision Project. MVP field sites provided direct practicum experience with the population for these students. Other practica included orientation and mobility, home liaison teaching, and vocational placement. MVP staff supervised these students in practica. MVP staff also provided preservice and inservice training in regular workshops planned for these students and teachers in the field registered for this course of study.

Evaluation Component

A second major function of the training and evaluation component was the evaluation of the effectiveness and the efficiency of the Model Vision Project operations. Three major levels of evaluative data were collected by the MVP evaluation staff: 1) educational-developmental progress of children enrolled in MVP classrooms; 2) effectiveness of parent, agency staff, and paraprofessional training programs; 3) overall effectiveness and efficiency of the service delivery system.

Two types of data were employed to evaluate the educational/developmental progress of MVP children. The first consisted of results of standardized assessment instruments administered by the diagnostic component as a function of that component's comprehensive assessment of those MVP clients whose need for diagnostic services was considered to be a high priority.

The second type of data consisted of precision teaching data which entailed having the classroom teacher record each day the rate at which a child performs a targeted behavior during the daily intervention procedure planned for teaching the child the pinpointed skill. The resulting rate data were allotted on six cycle semilogarithmic graphs and analyzed on an individual basis by the teachers to determine if the child was progressing satisfactorily.

In terms of training effectiveness, the evaluation of MVP training activities emphasized the validation of staff developed training modules to be used by parents, paraprofessionals, and community agency personnel. Module validation was based on pre-post module performance of trainees on criterion reference tests. These performance data were analyzed using conventional statistical significance tests to document and observe post training improvements in module participants.

Decisions regarding overall project effectiveness and efficiency were based on several types of data. Two aspects of this data base have been described above - data on the progress of children in MVP affiliated

classrooms and validation of data on MVP training modules. The extent to which project staff time was utilized efficiently was evaluated by a modification of the Program Evaluation and Review Technique (Merbler and Bourgeault, Note 1). 'This modified Program Evaluation Review Technique (PERT) analysis was designed to provide a fair warning of staff service delivery system overload as well as give an estimate of the impact of altering fundamental project operational routines (e.g., geographical catchment area) on MVP service delivery capacity. Another major focus of the overall evaluation of MVP effectiveness was cost efficiency. The primary evaluative question regarding project cost factors was whether MVP was providing services of sufficient scope and to a sufficient number of clients to be judged economically feasible and replicable. Consumer evaluation of MVP services was the final category of the evaluative data pertaining to overall project effectiveness. The parents of target children who received MVP services were requested to complete questionnaires which were designed to solicit ratings of MVP services they themselves have directly received (e.g., training, social work) and/or that their children have received (e.g., educational diagnosis, field services).

MVP STAFF POSITIONS

By nature of its being a demonstration project, the Model Vision Project was initially responsible for determining all of the services it deemed necessary for the target population. It was necessary, therefore, to create positions and generate job descriptions for these positions which would address all necessary services, direct and indirect. The following is a list and description of staff positions which comprised the Model Vision Project. With changes in personnel and project emphasis, time commitments and responsibilities for several positions were changed.

Project Co-Director, Training and Evaluation Co-ordinator,
Dr. Randall K. Harley

As project co-director, Dr. Harley shared responsibility for seeing that the agency, George Peabody College, carried out its commitment according to the stipulations in the contract. He participated with Dr. Bourgeault in overseeing the entire project from beginning to end, from the recruitment and selection of staff until goals and objectives of the project were completed. He was specifically responsible for all goals and objectives related to personnel training, parent training, evaluation, and dissemination.

Project Co-Director, Field Services Co-ordinator,
Dr. Stan Bourgeault

As project co-director, Dr. Bourgeault shared in overall responsibility for program implementation. As field services co-ordinator, he was responsible for the following: (a) coordination of all aspects of the project field program and staff including the mobility services, the social work services and the infant/toddler program; (b) coordination of project services with established agencies and agency staff such as the home teacher working in the project from Services for the Blind; (c) supervision of the three project classes at Hillman School; (d) development and implementation of a communication network and protocols to facilitate intra-project and interagency exchange; (e) coordination of inter-district contact between Nashville Metropolitan Schools and outlying sections of the target area; and (f) coordination of acquisition of all necessary materials and equipment to implement field services.

Diagnostic Supervisor - Dr. Rebecca F. DuBose

The diagnostic supervisor was responsible for the following activities: (a) supervision of all diagnostic services and diagnostic staff personnel; (b) supervision of all graduate students participating in diagnostic services; (c) liaison between project staff and Child Study Center; (d) conducting all final staff conferences; and (e) preparing quarterly reports on all diagnostic services.

Project Coordinator

The project coordinator had responsibility for administration and supervision of the entire operation of the center. S/he followed the proposal to see that goals and objectives were met as planned. S/he insured the coordination among the center staff as well as the schools, agencies, and parents participating in the program. A primary responsibility was to see that all children and parents in the target population were made aware of the opportunities presented by the program and properly enrolled as participants. S/he helped to plan and coordinate the meetings of the advisory council. S/he was responsible for planning and coordination of the dissemination activities, the writings of reports, making purchases, following the budget, and insuring that monies are properly accounted for.

Project Evaluator

The project evaluator assisted the project manager in seeing that the center program was evaluated according to the goals and objectives specified in the proposal.

The role of the project evaluator in the center consisted of:
 (a) monitoring the progress data on children and recommending programming procedural changes as indicated by the data; (b) monitoring the data collected on parent and teacher training operations and recommending programming procedural changes as indicated by the data; (c) monitoring and evaluating center effectiveness in terms of progress toward stated goals, diffusion and effectiveness of services to eligible clientele, and cost/benefit analysis.

Diagnostic Coordinator

The diagnostic coordinator had the following responsibilities:
 (a) coordination of identification of project clients; (b) implementing screening procedures; (c) scheduling and coordinating all diagnostic assessments; (d) writing educational assessment reports; (e) assembling written assessment reports; (f) overseeing prescription planning; (g) participating in follow-up assessments of pupil progress; and (h) participating in in-service training of project staff.

Educational Diagnostician

The diagnostician(s) cooperated with the diagnostic coordinator in: (a) identification and screening; (b) diagnostic assessment; (c) writing educational assessment reports and (d) participating in prescriptive planning.

Psychological Assistant

The psychological assistant was responsible for: (a) conducting psychological testing; (b) conducting parent interviews; (c) participating in final staffing; and (d) completing written psychological reports.

Clinical Teacher

The clinical teacher was primarily responsible for the training and upgrading of competencies of project staff. S/he planned and coordinated the in-service workshops for related agency personnel such as aides, houseparents, administrators, and supervisors. S/he organized and supervised the parent training program. S/he was also responsible for developing training packets and instructional materials. The clinical teacher also served as a resource person on a consultative basis to teachers in the field working with individual MVP clients.

Classroom Teachers

Teachers employed in the Harris-Hillman School met Tennessee Certification requirements as teachers of multi-impaired and as teachers of visually impaired. (100%). The teacher for the infant/toddler program (50%) was an early childhood specialist. They were responsible for implementing the programming for their children suggested by the diagnostic team, revising programming as necessary, and monitoring the progress of their students.

Home Liaison Teacher

The liaison teacher was responsible for family-oriented and community-oriented services: (a) communication between the center program and the parents, (b) home teaching of the child and (c) communication with community agencies on behalf of the project and clients and their families. The communication responsibility started from consultation with the parents about placement in the center program, and continued with follow-up activities at home to complement the instruction at school. The home liaison teacher cooperated with the clinical teacher in the parent training program and coordinated a program training parents to work with other parents. As community liaison, s/he was responsible for working with agencies to locate appropriate placement for clients, contact agencies on behalf of the project to determine services available to the target population, and help coordinate agency requests for training and consultation. S/he also developed training packets and instructional materials.

Mobility Specialist

The orientation and mobility specialist was responsible for overseeing the teaching of pre-cane mobility skills and concepts in all of the programs in the project. He gave special instruction to each pupil needing to learn cane techniques in the secondary and pre-vocational levels of the project. He assisted in in-service training of staff members. He was responsible for training orientation and mobility technicians at MVP field sites to ensure continuation of O & M services to the population following MVP withdrawal.

Vocational Counselor

The vocational counselor was responsible for providing information to project clients and parents concerning vocational habilitation and placement services. S/he was responsible for seeing that effective communication occurred between the personnel at the identified vocational and training sites and the client needing such services. S/he helped the center to set up an effective evaluation, training, and placement plan for each client. S/he was responsible for following through any placement, acting as a liaison person between the center and the employer.

Social Worker

The social worker was assigned to the center. S/he assisted families of the target population with general management of home/community problems. S/he was also responsible for community agency awareness of project client needs.

TARGET POPULATION AND TARGET AREA

Target Population

Description

The target population for the project included those severely handicapped children and youth from birth to 22 years of age whose visual impairment is one of their primary handicapping conditions. Additionally, these children manifest handicapping conditions such as profound or severe mental retardation, cerebral palsy, emotional disturbance, or a combination of these conditions.

Every child was a multihandicapped child whose handicaps, either singly or in concert with one another, render him severely or profoundly impaired. Further, it should be stated that the determination of visual impairment did not rest solely on reduced visual acuity or visual field restriction. Significant functional visual disability was the principal visual performance criterion.

Table 1 shows the numbers and ages of the identified MVP population in the catchment area. All of this population were screened by the MVP. Approximately one half of the identified population received comprehensive diagnostic services as reported in Goal 4 of the Program Goals section of this report. Approximately one third of the population was enrolled in MVP classes. Through indirect services such as clinical teaching activities, home liaison teaching, agency staff inservice training, consultation, referral services and distribution of MVP materials; all of this population were served by MVP to some degree.

TABLE 1

Number of Project Participants

Type	Age						Total
	0-2	3-5	6-8	9-12	13-18	19-22	
Severely/Profoundly Multihandicapped with Visual Impairment Year Three	11	11	13	23	37	16	111
*Cumulative totals since project beginning	12	13	16	25	36	19-22+ 25	127

*moved out of region - 5
unable to locate - 2
deceased - 1
over age 22 - 7

Table 2 shows the distribution of the target population among types of educational placement in the last year of the project.

TABLE 2

Educational Placement of Target Population

Age	Harris- Hillman	Infant Class	Tenn. School for Blind	Other Day School	Clover Bottom Sp. Ed.	Home Teaching	None (By parent choice)	Total
0-5	2	10	0	4	1		3	20
6-10	7	0	5	1	3	2		18
11-15	13	0	6	5	8		1	33
16-21	16	0	1	4	19			40
Total	38	10	12	14	31	2	4	111

7 - Over 22

8 - Moved out of region or unable to locate

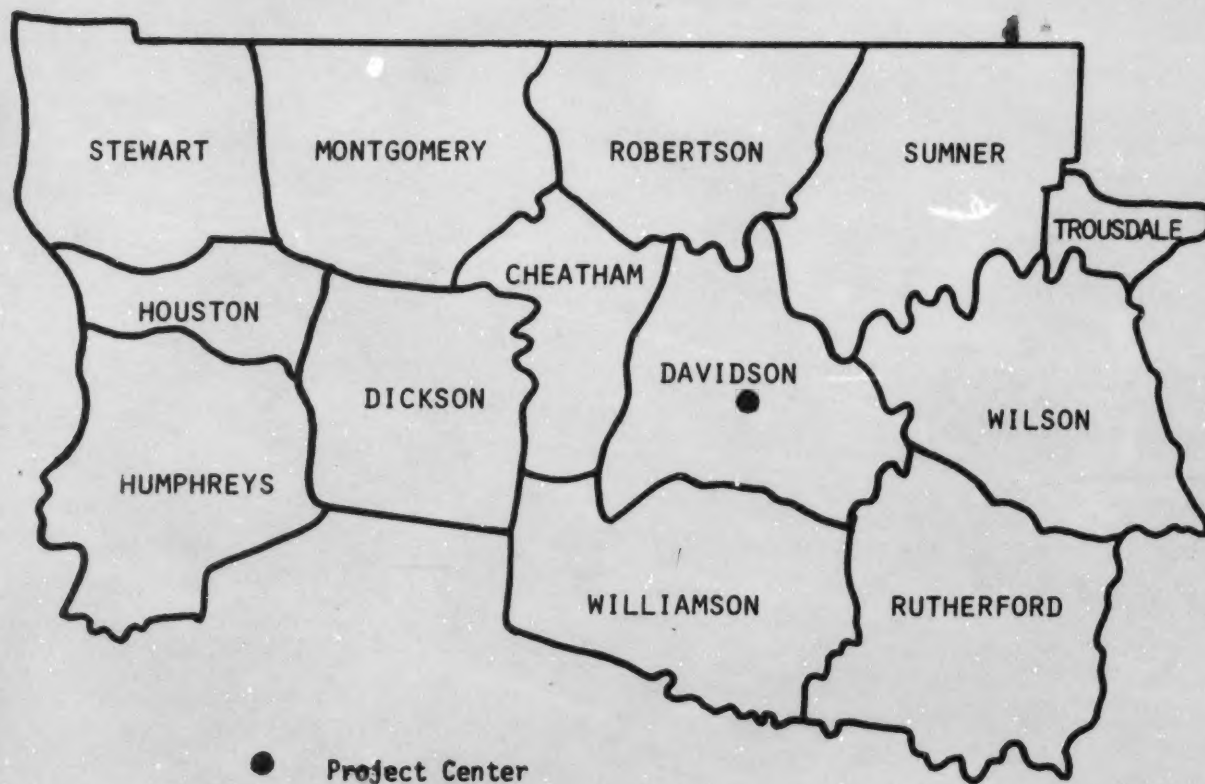
1 - Deceased

Catchment Area

The principal target area of the project was Metropolitan Nashville/Davidson County. In addition, contiguous counties were included inasmuch as they frequently negotiate contractual services for high-risk, low-incidence populations. Those counties are as follows: Cheatham; Dickson; Robertson; Rutherford; Summer; Williamson; and Wilson. These counties include the principal population centers surrounding the Metropolitan Nashville area. (see figure 2)

In the second year of the project, the catchment area was expanded to include other outlying counties; however the project received few referrals from these counties. The project generally served these counties through clinical teaching and consultative activities. Project staff worked cooperatively with those responsible for the education of individual MVP clients from outlying counties to ensure the provision of appropriate services upon their return to the local community.

Figure 2
TARGET AREA



Map of Catchment Area

Figure 2

IMPLEMENTATION

PROGRAM GOALS, OBJECTIVES, AND METHODS OF IMPLEMENTATION

In order to ensure that the services identified as needed to implement the model were addressed, twelve goals were outlined for completion within the three years of the project. The Model Vision Project defined short and long term objectives to facilitate realization of these goals. Through quarterly monitoring of progress toward these objectives, activities have been planned, implemented, and changed when necessary as project priorities were adjusted during the three year period. The following is a listing of each goal; the procedures implemented by the project, problems encountered in implementation, alternative procedures suggested to programs replicating services; and evaluation or documentation of progress toward proposed objectives.

Program Goals

Goal 1. To engage in activities requisite to the establishment and maintenance of a demonstration service center for severely handicapped children and youth whose visual impairment is one of their primary handicapping conditions.

Goal 2. To have established a system through which all community provisions for the target population will be identified.

Goal 3. To have developed a master plan for direct services to the target population with maximum dependence on existing state and local facilities and programs.

Goal 4. To have a process established through which each child in the target population may have access to adequate diagnostic/evaluative facilities.

Goal 5. To have program and process established through which every family of severely handicapped, multi-handicapped children who have a visual impairment may have full access to all necessary support services, especially to assistance with their major role as principal behavior managers.

Goal 6. To have available to each child in the target population a system through which timely, individualized prescriptive educational programs can be produced.

Goal 7. To implement necessary quality control services so that the target population will have access to programs staffed with competent personnel to insure adherence to and maintenance of a prescribed individualized instructional program.

Goal 8. To organize and implement a recreation plan through which each member of the target population will have access to suitable recreation resources in order to improve social adjustment.

Goal 9. To identify a process through which each primary member of families of the target population will have access to counseling services and to respite care on an emergency basis.

Goal 10. To establish and/or expand programs so that each youth in the target population will have access to appropriate pre-vocational and vocational training experience, and/or to vocational rehabilitation evaluation, with individualized rehabilitation plan which meets his needs in order to approximate financial/social independence.

Goal 11. To develop a community-wide public information/public education program, to alter public attitudes, thereby increasing acceptance and active support of both government and private sectors.

Goal 12. To expand and enrich a full range of orientation and mobility services for the target population, including consultation and direct experience in acquiring, or developing readiness acquisition of competence in use of pre-cane and cane techniques.

Goal 1: To engage in activities requisite to the establishment and maintenance of a demonstration service center for severely handicapped children and youth whose visual impairment is one of their primary handicapping conditions.

L 1.1 (L - Long-term: 3 year period) To incorporate the project advisory council as a recognized consultative body to the State Advisory Council for Special Education.

Implementation: The MVP Advisory Council was established during the planning stage of the project. The eleven members invited to participate were representatives from the community whose involvement was considered to be crucial in promoting cooperation and coordination of efforts with key community agencies and parents whose participation would assist the project in targeting family needs. The council met 6 times during the project's initial year. Through these meetings council members were apprised of all initial activities and goals. Further staff input to the council occurred through the quarterly reports shared with all members. Council members assisted the staff through providing suggestions and advice regarding expanding services, channels of communication at local and state levels, and future activities of the project. The council continued to meet on a quarterly basis through the second and third years. Through the cooperation and support of members of the council, maintenance of services by community agencies without direct MVP involvement was facilitated in anticipation of termination of the project. In planning the Outreach Phase of the Project, the council provided valuable assistance in identifying feasible replication sites, liaison with projected sites,

suggestions of procedures for identifying areas with high incidence of MVP target population, etc.

In the first year of the project, contact was made with the State Advisory Council for Special Education in an effort to establish a process for incorporation of the MVP as a consultative body to the council. Recognition by the State Council would provide the channel for input on behalf of the severely handicapped to a group responsible for making policy recommendations for the entire state special education program. Person-to-person communication with the council was not maintained, but the MVP will continue to channel written information (final report, Outreach proposal) to the council.

L 1.2 To routinize the acquisition of necessary supplies and materials.

Implementation: Facilities and office space for personnel were secured by the second month of project operation. Necessary supplies and materials were ordered and received within the same time period.

Routine procedures for obtaining materials were established, and the staff received notification of the procedures. Within the framework of this project, the project manager assumed responsibility for coordination of purchasing and providing information to cooperating agency personnel regarding availability of materials for the multi-handicapped visually impaired. MVP cooperated with several agencies who were unaware of funds and free materials available to their visually impaired clients. The project manager assisted them in utilization of these resources. Such information was also made available to MVP families. The families were assisted in locating resources and materials which related to their specific needs as well.

L 1.3 To have facilities prepared to accept responsibility for continuing implementation of project services.

Implementation: During the initial phase of project operation, MVP negotiated with four agencies whose cooperation was seen as crucial to the success of the project. The results of these negotiations were service contracts which delineated agency and project responsibilities for providing services and facilities for the target population. The project served in a catalytic role between agencies to coordinate identification of project participants, placement of participants, and services provided to participants. As MVP had a variety of relationships with the different agencies, the service contracts aided in clarifying the individual relationships. The agreements in the contracts constituted commitments on each agency's part to the purpose of developing, refining, and maintaining comprehensive services within each agency's delivery system for the multihandicapped visually impaired. Arrangements for direct services to children and families were given first priority. Procedures for indirect services, such as training staff members and consultative services, were developed gradually as needs were clarified. Arrangements were carefully planned to insure the continuation of project initiated activities after the withdrawal of direct support.

The Nashville Metropolitan Schools has provided comprehensive educational services to 39 MVP clients for three years and will continue to serve this population, making available needed auxiliary services such as physical therapy, speech therapy, orientation and mobility training. Twelve (12) MVP clients were served at the Tennessee School for the Blind. Educational and diagnostic services will be available through TSB for the current MVP population and those to be identified in the future. Clover Bottom Developmental Center provides educational services in special education classes, orientation and mobility training, vocational training when appropriate for clients beyond school age, and training methods for clients beyond school age for whom vocational services may not be appropriate. Thirty-one (31) MVP clients were served at Clover Bottom. MVP has worked very closely with these agencies in the development of these services through training workshops, consultation, and diagnostic services.

In the third year of operation, the emphasis of the MVP was on identifying resources for maintenance of specialized services needed by the target population and their families. Arrangements were made with agencies providing vocational training for an exchange of information regarding skills required for acceptance into programs and referrals of individual clients. Agencies serving children of pre-school age were contacted, visited, and consulted with in anticipation of possible placement of MVP infant/toddlers in some of these programs. Contacts were made on behalf of individual clients with other programs which offered educational/training services to clients requiring specialized services due to severe behavior disorders to provide assistance to the staff in working with the visually impaired. These specialized services will continue to be available to the MVP population as needed.

Funding problems with other agencies have precluded finalized arrangements for maximum cooperation between MVP and these agencies in some cases. For example, a plan was developed for a training and habilitation center to make available vocational training services to MVP clients 6-12 years old at Clover Bottom Developmental Center and Harris-Hillman School. As funding was unavailable for this purpose, it was decided that the center would serve those MVP clients leaving the school system at 22 through an individual referral system. Three (3) MVP clients were involved in this process. The need to work within established systems may sometimes limit the abilities of other agencies to expand their services beyond what is currently provided through the agencies. Making these services available to a broader population may be the extent of the cooperation these agencies can offer.

At least 75% of the critical MVP services and processes have provisions for continuation following MVP withdrawal. Community agencies have cooperated to a great extent in making these services available and appropriate for the MVP population.

Documentation: Agencies Involved in Maintenance of Services

Metropolitan Nashville Public Schools - Educational, diagnostic services

Tennessee School for the Blind - Educational, diagnostic,
parent services

Clover Bottom Developmental Center - Educational, diagnostic,
vocational, parent services

Regional Intervention Project - Educational, parent services

Child Study Center at George Peabody College - Diagnostic,
parent services

Tennessee Services for the Blind - Parent services

Early Development Assistance Project, Experimental School of
the Kennedy Center at Peabody College - Infant/Toddler
Educational, parent services

Outlook Nashville - Infant/toddler educational services

Sertoma Easter Seal Child Care Center - Infant/toddler educational
services

Rochelle Training and Habilitation Center - Vocational services

Goal 2: To have established a system through which all community provisions
for the target population will be identified.

L 2.1 To develop a system of updating of program index to guarantee
timeliness.

Implementation: The MVP developed a process for identifying all community provisions for the target population. Agencies whose cooperation with MVP was considered to be crucial in the initial stages of the project were already identified. In order to locate all other resources in the community, information was gathered from a state directory of services for the developmentally disabled, staff, advisory council members, etc. The range of needs of the population and their families were identified, and the first task was to identify resources of services which could meet these needs. Telephone contacts with the providers of these services ascertained the current and future availability of each agency's services to the multihandicapped visually impaired. Fifteen (15) community agencies were contacted in this manner regarding making their services available to the target population or providing a new services needed by the population which was closely related to the services currently offered. It was found that the majority of the agencies contacted were very interested in staff training or consultation concerning working with the severely handicapped, multi-handicapped, or visually impaired so that they could serve this population appropriately. For example, contact with the Child Intervention Project yielded a "trade-off" agreement. This agency would serve an MVP client needing their expertise in behavior control if MVP staff would consult

with their staff regarding the client's visual handicap. In general, lack of experience with this population was the primary barrier to service delivery. As part of the purpose of MVP, arrangements for workshops or consultation were made in these or follow-up telephone contacts with interested agencies. In this manner, community awareness of the project and its population was enhanced as well as increasing the availability of a wide variety of services to the population.

The types of resources located included medical, educational, diagnostic, legal, recreational, vocational, day care, respite care, residential, family support, and babysitting. The information gathered was compiled in a Community Resources List which included all pertinent information about each agency or resource including services offered, eligibility requirements, geographic limitations, fees, contact person, address, and phone number. In the interest of efficiency of staff time utilization, a mail-out survey form was developed which could be shared with other programs as a means for making initial contact with agencies and gathering all pertinent information easily. Follow-up telephone contacts can then be limited to those agencies who do or could serve the target population. (See Mail-out Survey Form in Appendix B.) The MVP found the Tennessee-Peabody Liaison and Referral Office to be of invaluable assistance in locating resources for specific needs of individual clients. All agencies who were to receive MVP assistance throughout the year were included in the Resources List which assured reasonable timeliness of the list.

L 2.2 To establish a dissemination system to afford widest possible knowledge and utilization of resources.

Implementation: The Community Resources List was distributed to every parent/guardian of MVP participants in order to assure that this resource information remained available to them after termination of the project. As information about the project became more widespread in the community, eight (8) requests for the list came in from agencies in the community, and the list was distributed accordingly. The MVP staff and personnel working with the MVP population also received the list, read it, discussed it, and utilized it. (See Community Resources List in Appendix B)

Evaluation: The usefulness of the Community Resources List was evaluated by telephone survey of parents in conjunction with an evaluation of respite care resources.

Twenty-one parents or guardians were surveyed regarding the receipt and utility of the community resources list. 61% of the families recalled receiving the list. The remaining 34% of the families requested a copy. 92% of the families who received the list found it useful and a similar proportion expected to use it in the future. The remaining 8% of the sample receiving the list felt it needed improvement.

Goal 3: To have developed a master plan for direct services to the target population with maximum dependence on existing state and local facilities and programs.

L 3.1 To know specific service needs of every member of target population.

Implementation: In the screening and referral process of all MVP participants, all handicapped conditions were noted and ranked according to severity, providing a preliminary list of needs to be addressed. It was found that (1) severe visual was the most distinguishing characteristic of the clients seen by the diagnostic staff; and (2) mental retardation, physical impairment, and social retardation were major problems requiring additional professional services. (See Rating of Severity of Handicapping Conditions in Appendix B.) More specifically, during the diagnostic assessment of clients, the family interview yielded information relating to the individual needs of the clients and their families. A parent needs assessment survey was done to determine parental perceptions of their needs for information, training, support, etc. This additional information was combined with staff perceptions of client and family needs. It was determined that many of the needs of individual clients were common among the population and thus provided the basis for the development of MVP services to be offered and those to be located in the community. MVP utilized the specialized expertise in the community to upgrade MVP-provided services and offered MVP expertise to the community to upgrade community-based services.

All preliminary data on student needs were analyzed and procedures established to reconcile needs with staff job specifications. In accordance with Goal 7, several procedures for determining competency requirements for meeting the needs of the population, upgrading competencies, adjusting competency needs, and assuring quality services to the population. See Goal 7 for a complete report. Staff workloads were adjusted to effect maximum service delivery for the smallest possible dollar cost on the basis of a modified PERT analysis of staff time utilization.

One aspect of direct service delivery in any system which should be considered is staff liability in transportation, administering medication, legal constraints on utilizing physical therapy techniques in classroom programs, confidentiality, etc. These issues were investigated as they related to programs in this area and clarified for the staff. As a result a number of staff members secured personal, professional liability insurance. It is highly recommended that any system providing direct services to a handicapped population investigate the legal ramifications in their state involved in provision of these services.

L 3.2 To establish and maintain an adequate transportation plan among clients and project staff to assure accessibility of clients to services and service staff to service areas.

L 3.3 To monitor and assist in the maintenance of a functional, diversified transport network primarily dependent on family, agency, and public services, augmented by the project center.

Implementation: In the initial stages of the project, gaps in the transportation network for families of MVP clients were identified, and the project initiated transportation arrangements including reimbursement for gasoline expenses when needed, provision of taxi services, and utilization of college practicum students for transportation services on an emergency basis. It was found later that transportation needs were not significant, and any individual problems could be easily solved. Families living in surrounding counties either provided their own transportation into the center for diagnostic services, or the county systems made arrangements. The Nashville Metropolitan Schools provided regular transportation for students served within that system. It was found that the Office of Developmental Disabilities provided funds for transportation related to necessary services when not available through any other agency, and families were apprised of this resource.

Goal 4: To have a process established through which each child in the target population may have access to adequate diagnostic/evaluative facilities.

L 4.1 To have a full individualized evaluation and program prescription for every known member of the target population.

Implementation: As the diagnostic services provided by the MVP required from 60 to 90 man hours per client in preparation, assessment, scoring, programming, and report-writing, it was found that it was impossible for every MVP participant to receive a full individualized evaluation and program prescription. It was decided that students who were to be placed in MVP educational programs would receive diagnostic services, as MVP would be best able to monitor the progress of these students, make necessary adjustments in their prescriptive programs, and work most closely with the teachers of these students. Priorities for emergency diagnostic services were established as follows: (1) First priority was given to children below seven years of age who were not receiving any educational services, (2) children who were enrolled in programs not specifically designed to meet their needs received second priority, and (3) children enrolled in project programs received second priority for emergency evaluations, however they were scheduled for evaluations if critical decisions such as program placement could be facilitated by assessment information.

Evaluation: In the three years of MVP operation, a total of 54 clients received individual assessments with prescriptive programs. There were 38 reassessments with updated prescriptive programs.

L 4.2 To document a master fiscal support plan for comprehensive diagnostic, evaluative, and prescriptive services.

L 4.3 To document continuum needs and organize budget and program expansion proposals to/for participating community service agencies.

Implementation: Whenever possible, outside evaluation services were recommended to replace or supplement center evaluations. It was found that there was a shortage of trained diagnosticians within community agencies, and there was a need for counseling services to enrich existing diagnostic services. A listing of all relevant community agencies from which the child or family could receive services was included in the individual diagnostic evaluation reports.

Due to the multiplicity of various systems and agencies who would be responsible for taking over diagnostic services for the MVP population, it was impractical to present a budget or fiscal support plan to these agencies based on MVP diagnostic costs. As the primary purpose of MVP was to work within existing systems in the community to provide appropriate services to the target population, a more realistic and acceptable procedure was to approach each agency about their individual needs in developing or expanding their diagnostic services. The primary placement area of each MVP client was identified, and each agency providing primary direct services was contacted. They were invited to send a representative to observe the assessment of clients within their area of service-delivery. Following the diagnostic evaluation, MVP forwarded a copy of the report to the agency and worked with the agency in implementation of the prescriptive programs. In preparation for continuation of diagnostic services by these primary agencies, each agency identified their own needs and personnel to be involved. Training of agency personnel was seen to be the primary need and best means of upgrading services to this population within the established framework of each agency. To this end, the following is a list of the activities in which MVP was involved in the surrounding area:

- 1) Extensive workshop for psychologists of the Tennessee Department of Mental Health on assessment of the severely handicapped.
- 2) Inservice training workshop for public health nurses to instruct them in visual screening techniques for severely handicapped children.
- 3) All-day inservice training workshop for school psychologists from Metropolitan Nashville Public Schools.
- 4) Metro School Psychologists scheduled observation of MVP assessments.
- 5) Metro School Psychologists were assisted in assessment of three clients.
- 6) Two Metro School Psychologists received inservice training at the MVP/Child Study Center in preparation for their new responsibilities with MVP clients.

- 7) MVP team assisted Tennessee School for the Blind in re-assessment of a MVP client.
- 8) MVP team assisted Vanderbilt Department of Mental Health in evaluation of one client.
- 9) MVP team assisted Regional Intervention Project in evaluation of one client.
- 10) Workshop for parent workers from Tennessee Services for the Blind to instruct them on visual screening and screening-based programming of visual activities for multihandicapped visually impaired children.
- 11) Inservice training workshop at Shelbyville Child Development Center on developmental assessment and programming in Shelbyville, Tennessee.
- 12) Pre- and Inservice training for graduate students at Peabody College on assessment techniques for the severely handicapped.
- 13) Training for students at Middle Tennessee State University in Murfreesboro, Tennessee on administration of the Developmental Activities Screening Inventory.
- 14) Workshop at Clover Bottom Developmental Center in Donelson, Tennessee on programming for severely handicapped children.
- 15) Two class presentations for students at Peabody College on vision-screening and training.

To facilitate takeover of diagnostic services, each agency has received the diagnostic files of MVP clients being served through that agency. Tennessee School for the Blind, Metropolitan Nashville Schools, and Cheatham County have assumed responsibility for continued diagnostic services for all children receiving educational services through these agencies. Clover Bottom Developmental Center will continue to provide diagnostic services to clients not enrolled in Metro-Davidson County Public Schools. The Child Study Center at Peabody College is available for diagnostic services to preschool children not currently served by other agencies having access to diagnostic services. MVP staff will occasionally evaluate children for demonstration purposes when needed and have retained a copy of each child's record for this reason.

Goal 5: To have program and process established through which every family of severely handicapped, multi-handicapped children who have a visual impairment may have full access to all necessary support services, especially to assistance with their major role as principal behavior managers.

L 5.1 To document a validated rank order list of critical issues, as perceived by families.

Implementation: A survey of family needs and priorities was conducted during the second quarter of the first year. The results of this survey yielded information about service gaps and needs which the MVP needed to address. It was essential to address one need at a time to fully meet these needs. Where possible, delivery of specific services was added to or adapted to job descriptions of the current staff. Identified family needs and individual child needs were synthesized to form the MVP plan for a comprehensive service delivery system for the multihandicapped visually impaired. More specifically, parent perceptions of their needs for information, training, counseling, support, transportation, etc. were identified, and the project developed procedures and programs for meeting these needs. (See Family Questionnaire in Appendix B.) Locating resources in the community to meet these needs was an ongoing process for the MVP. The extensive community survey outlined under Goal 2 served this purpose.

L 5.2 To package and disseminate family information modules on subjects of documented high relevance.

Implementation: Family training modules related to behavior management, child development, language development, daily living skills, etc. were developed and disseminated to parents. The modules were drawn from diagnostic prescriptions, written training modules, and commercially prepared materials. Information packets concerning legal issues, insurance programs for the handicapped, community resources, etc. were also compiled and disseminated. The role of the home teacher was clarified. At the home level, the home teacher provided direct training and information service to families and insured the carry over of carefully planned school curriculum. At the school level, the home teacher served as a liaison between school and home and a source of information to the teacher regarding practicality and reality of expectations of the family. At the agency level, the home teacher arranged necessary community services for the target population and assisted in training of key personnel in the skills necessary to assume responsibility for the target population.

Relevant parent groups in the community were identified and parents' participation encouraged - Tennessee Services for the Blind; Davidson County Association for Retarded Citizens. A joint parent group was established with Project Change (a BEH-funded program serving the severely/profoundly retarded) for purposes of advocacy and action. In the last part of the third year, meetings were scheduled to coincide with DCARC so that the MVP/Change group could become identified with a well-established and active advocacy group and continue after termination of both projects.

L 5.3 To develop an evaluation process for monitoring utilization of family services.

Implementation: A survey form was designed for telephone use to evaluate the usefulness of the Community Resources List in meeting parent needs for information about resources for their children.

A survey form was designed for telephone use to evaluate the services received by families from MVP through the three years of operation and to determine needs which were not met.

In the Infant/Toddler program, parent needs were constantly monitored and addressed as a result of the involvement of parents in the daily program.

Evaluation: Of thirty parents called, nineteen parents or guardians of MVP children were reached for survey by telephone during the last quarter of the final funding year. (See Appendix B for a copy of the survey form.) The survey probed parental evaluation of MVP services. Fifteen of the nineteen parents reported their children had been evaluated by the MVP diagnostic team. Overall, parents rated MVP diagnostic services (3 point scale: 1=poor, 2=good, 3=excellent) as very good to excellent (X rating = 2.76). Parents reported a better understanding of their child's strengths and weaknesses following evaluation (2.63) and the feedback as clear and easy to understand (2.83). The survey indicated nearly all parental questions about their child's performance were answered (2.56) and that they received substantial information which helped them work with the child at home.

All nineteen of the parents surveyed reported that their child had or was receiving educational services and those educational services were rated as very good to excellent (rating = 2.63). Very few of the parents surveyed reported a need for home visitation or social work services. Only four parents reported a need for home visitation and social work services and those services received a very good to excellent rating (2.62 and 2.66). Overall parents rated the services delivered by the MVP as very good to excellent (rating = 2.82). When questioned about changes or improvements parents would like to have seen, the following improvements were suggested. Parents regarded transportation to and from school activities as a problem. Several parents wanted an expansion of physical therapy services and the addition of summer day school programs. Several parents also commented on the benefits they received from observing the child during the evaluation process or in working with the child and teacher in school programs. The following count captures the tenor of their reports. "I, myself, learned a great deal - I became aware of the little things that she does and look at her more closely now." A majority reported they benefited from the supportive aspects of meeting with other parents. The statement by a mother that "We no longer felt we were the only ones with a child like ours" typified parental remarks regarding support.

L 5.4 To arrange provisions for home liaison services following MVP withdrawal.

Implementation: The home liaison teacher worked with the liaison worker at Tennessee School for the Blind concerning several MVP clients which were on her caseload. Information regarding other clients who could be eligible for her services following MVP termination was exchanged. A potential client list was left with the worker.

The clinical teacher and home liaison teacher met with representatives of the Parent Training Component of the Community Services Department at Clover Bottom Developmental Center to determine the availability of these services to the MVP target population. These services are available and were utilized by one family during the third year.

MVP provided a number of workshops to rehabilitation workers and parent workers of the Tennessee Services for the Blind to assist them in provision of their services to the multihandicapped population. MVP has negotiated with this agency throughout its operation for takeover of home liaison services. The agency has agreed to provide a half-time parent worker to serve the multihandicapped visually impaired.

The home liaison teacher provided inservice training to direct service practitioners of the Davidson County Department of Human Services Protective Services, Adoption and Foster Care Units.

Goal 6: To have available to each child in the target population a system through which timely, individualized prescriptive educational programs can be produced.

L 6.1 To provide responsive, current, program prescriptions for every child in target populations.

Implementation: As reported under Goal 4, it was found to be impossible to provide diagnostic evaluations and resulting prescriptive programs to every identified member of the target population. Through the screening process, sufficient information was gathered by the screeners to provide primary caregivers with suggestions for objectives to be set and activities to help reach these objectives.

The individualized program prescriptions provided for other clients were developed directly from the findings of the assessment team during the diagnostic process and constituted a part of the comprehensive evaluation report. These programs have included long term goals, short term specific performance criteria, objective, activities, procedures, and materials suggested to help the individual move from his/her current level of functioning in every developmental domain to the next level. The evaluation reports were provided to the MVP,

teacher, and parents. They included medical and/or ophthalmological information and educational, psychological, and family recommendations to be used by teachers, parents, or primary caregivers in establishing goals and objectives for a one year period. Specific resources in the community which could be helpful to the parents were also listed. (See a copy of an evaluation report in Appendix A.)

L 6.2 To document, implement, and monitor a cyclic prescriptive program revision system.

Implementation: The goal of reevaluating each child every six months was found to be unrealistic due to the large number of identified children. A more realistic goal was at least one reevaluation within an 18-24 month period following initial assessment. Any clients who could not be scheduled for formal reevaluations received extensive follow-up services from the diagnostic team. There was a total of 38 reassessments with updated prescriptive programs. After grant implementation it was found that the need for reevaluative services was not so crucial with the implementation of PL 94-142. Agencies providing educational/training services were required to develop an IEP for each student which involved initial assessment, monitoring of progress toward objectives, and reassessment. The prescriptive programs included in the evaluation reports were easily transferrable to an IEP format. The performance criteria included facilitated teacher measurement of progress toward goals and altering program objectives as needed. The diagnostic staff was always available to teachers or parents for assistance with program changes.

Goal 7: To implement necessary quality control services so that the target population will have access to programs staffed with competent personnel to insure adherence to and maintenance of a prescribed individualized instructional program.

L 7.1 To document identification of all personnel needs to maintain comprehensive services to target population.

L 7.2 To document identification of principal competencies required to perform necessary services.

Implementation: As a direct result of identifying the needs of the MVP population and their families, a list of competencies and skills needed to meet those needs was generated; the staff was interviewed to determine individual personnel needs to maintain quality services to the population. MVP staff inservice training was planned through the first two years to address deficiencies. Tuition waivers for course work at Peabody College were arranged for staff professional development.

Contract letters to each staff member included job responsibilities for each position. These job specifications were altered as changes

in project emphasis occurred. (See example of job specification outline for Clinical Teacher in Appendix C.) As job responsibilities were altered, so were the competencies required to meet these responsibilities. (See competencies developed for each position in Appendix C.)

L 7.3 To produce a functional system for evaluating employment eligibility.

Implementation: In evaluating an applicant for a specific position, the job responsibilities and competencies required were compared with information about the applicant's educational and occupational background and references. As competency-upgrading for the staff was ongoing through the first two years of the project, an applicant's strengths were considered to be more significant factors in the decision than weaknesses.

L 7.4 To document a process for evaluating performance of professional personnel required to maintain services provided the target population.

Implementation: In the three years of the project, two processes for evaluation of staff performance were designed and implemented. The first was a Standards of Performance Form which each staff member completed at the beginning of the second year. This form included staff member service delivery goals, criteria for goal achievement, and measurement strategies. It was found that projection of activities for a full year limited the area of staff performance to be evaluated.

The second, and more satisfactory system, was that of generating a contract with projected responsibilities for a year or less. Monthly each staff member completed a Planned Activities Sheet for the coming month which included the activities, anticipated completion date, and product. Activities not amenable to planning could also be listed. At the end of each month, staff members wrote in memorandum form all activities they had been involved in, addressing specifically those activities listed on the planning sheet. In this manner, any additional activities not anticipated could be listed, and explanation of any non-completed activities could be included. (See copies of a contract, monthly planning sheet, and activities memorandum in Appendix C.) Delineating responsibilities with a time frame seemed a satisfactory tool for individual organization of time. Project directors were also fully apprised of necessary activities completed which may have required time expenditure precluding the possibility of completion of other activities. The project manager kept a copy of all contracts, completed Planned Activity Forms, and memoranda which facilitated monitoring of project objectives, needs, and states of completion.

As the intent of this project was not to assure that quality services were available only through MVP staff, the MVP was extensively involved in training and upgrading competencies in those agencies who would be continuing to provide services to the target population after MVP withdrawal. Those activities listed

in the Dissemination and Marketing Activities list in Appendix D which occurred in the Nashville and surrounding area were planned for this purpose. The training and dissemination materials developed by the project were designed to upgrade competencies and, thus, improve services to the target population on a local, state, and national level through dissemination activities.

Goal 8: To organize and implement a recreation plan through which each member of the target population will have access to suitable recreation resources in order to improve social adjustment.

L 8.1 To document the validated recreation needs of the target population.

Implementation: A survey of MVP staff yielded a number of suggestions for recreational equipment, and the need for recreational alternatives was clearly supported. Parents, community resources, teachers, and some of the children themselves were interviewed to determine the range of activities being engaged in, parent expectation levels, and community options for additional recreation and leisure activities.

Evaluation: The survey indicated that the children and youth in the target population had an adequate amount of activities available to them during the school year. The two months of the summer presented the largest need for recreational alternatives.

L 8.2 To document available recreation programs, their site, admission criteria, and special provisions for the target population.

L 8.3 To distribute widely within target area information on availability of and access to all community recreation resources.

Implementation: Through the cooperation of the Physical Education Department of Peabody College, a comprehensive survey of recreational alternatives for the multihandicapped visually impaired in the surrounding area was conducted. The product includes available recreation programs, their locations, admission criteria, and special provisions for the target population. The alternatives listed address a wide range of skill levels.

A list of recreation and leisure time activities which could be engaged in at home and household materials which can provide entertainment as well as skill development was also compiled. (See Recreation and Leisure Time Activities in Appendix E.)

L 8.4 100 percent of the target population exercising recreation service options.

Implementation: A plan for a pilot recreation program was generated by MVP staff. As the staff was employed for four weeks to plan and implement the summer program, full implementation was impossible.

Preliminary activities were completed, but four weeks was not sufficient time to complete the program. (See "Basic Philosophy of Recreation for Severely and Profoundly Handicapped Visually Impaired Children" in Appendix E.) The list of activities and materials mentioned above, gathered by the orientation and mobility specialist, is a product of the recreation program plan.

The parent group responded to the need for recreational options by organizing a therapeutic recreation program. It was headed by a MVP parent and was operated separately from the MVP pilot recreational program.

Recreation information compiled was disseminated to all project families. With the two lists of recreation ideas, parents and caregivers should be able to engage children at some level in recreation and leisure activities.

Goal 9: To identify a process through which each primary member of families of the target population will have access to counseling services and to respite care on an emergency basis.

L 9.1 To document a process for identifying counseling and respite care needs of individual families of the target population.

L 9.2 To produce a systematic procedure for establishing priority counseling objectives with families of the target population.

Implementation: In the MVP diagnostic process, a family interview was scheduled for purposes of determining parental perceptions of their child's current functioning level, strengths, and weaknesses; family interaction with the child; pertinent medical and social history; parent priorities for the child and family; parent priority concerns; and family needs. The parent interviewer was often with the parents through their observations of the assessment procedure. In this manner, counseling and respite care needs could be identified for the individual family and recommendations made to the parents. These needs and specific recommendations of counseling resources were documented in the evaluation reports.

In the Infant/Toddler Class, parents participated with their children in the educational program. The teacher served in a resource capacity for the parents, and this relationship facilitated frank and open conversation between the parents and the teacher. Several parents indicated to the teacher that they needed to discuss problems or issues with someone. The MVP social worker began visiting the class regularly to give the parents an opportunity to discuss their priority concerns. A need for a regular parent group which dealt with personal and emotional issues was established. Individual parent concerns were addressed as they arose in conversation. It seems that counseling needs among parents are as individual as their children's. Parents' receptivity to recommendations for seeking counseling services may also vary.

Another means the project utilized for identification of parent counseling needs was an ongoing inservice training program for MVP staff directed by a professor at Peabody. Parent work and counseling was the major emphasis of several sessions. The staff was able to integrate the information each had from individual parents to generate a list of priority concerns of parents. These sessions were designed to provide the staff with the counseling skills necessary to work with parent problems which did not require professional counseling. Through training the staff was prepared to meet general counseling needs of parents and make specific referral for counseling services when indicated by the severity of need.

In accordance with the recognized need for a parent group which addressed counseling needs, the MVP social worker planned and facilitated regular group meetings which included interested parents from the Infant/Toddler Program. Through personnel changes, the home liaison teachers who had counseling experience took over responsibility for the group. Subsequent personnel changes resulted in a lack of personnel with counseling experience or background, and inservice training to address this problem could not be arranged in the last year. Therefore, the group itself was discontinued. Other means for providing informal counseling were maintained.

Respite care resources in the community were identified through survey. Only two agencies providing emergency respite care were located. One other agency was considering offering these services but found that funds for such a purpose were lacking. In one case, respite care was arranged through individuals who were interested in offering such help in an emergency. Medical and physical problems found among this population present difficulties for anyone other than agencies set up for residential care in providing respite care. On occasion foster parents who are caring for handicapped children are willing to provide short-term emergency respite care. Foster care services may be an alternate avenue for locating services on an individual basis.

A survey of parents' needs for respite care, knowledge of respite care resources, anticipation of utilization of identified respite care facilities was done in conjunction with evaluation of the Community Resources List.

Evaluation: Twenty-one parents or guardians were surveyed regarding the receipt and utility of the community resources list. 64% of the families recalled the listing of respite care facilities, but only 50% of those who recalled the resources would choose to use those facilities. Of the families who recalled receiving the community resources list, 100% knew of no other facilities which could care for children on a short-term basis. Nearly 92% of the parents who recalled receiving the list felt there was a need for more short term care facilities.

L 9.3 To present for dissemination a collection of information packets to supplement,

Implementation: A program for training parents to counsel other parents was initiated as a means of providing appropriate counseling services. It was felt that parents often benefit greatly from learning that other parents share similar problems and feelings about themselves and their children. The program curriculum included the following topics: development of visually impaired children with emphasis upon major developmental milestones in the cognitive and major areas and upon similarities and differences between development of visually impaired and sighted children; environmental determinants of behavior, including the influence of the parent and significant others in the child's life, antecedent conditions of behavior, and the role of reinforcement; fundamentals of task analysis and backward chaining; basic counseling skills including reflection and acceptance of feelings, and techniques designed to assist parents in expressing their concerns in specific terms; and an overview of group counseling techniques, including monitoring of participation by group members, maintaining a task focus in the group and preventing digressions, and facilitating exchange of ideas and experiences among members. The bulk of the training was carried out by the psychological assistant and one of the home teachers. The program was designed for about fifty hours of training, i.e. about three hours per week for four months.

Of the five parents who began the program, only one completed it. This high attrition rate could be attributed to several factors: exceedingly bad weather during the winter months, frequent illnesses among the children of some of these parents, lack of continuity in training due to these factors, and eventual decrease in motivation. The parent who completed the program had additional professional incentive which helped override the factors influencing the attrition of other parents.

It is felt that the program itself has tremendous merit and is highly recommended as a means for making counseling services available from within a system. In planning such a program, factors which could influence attrition of participants should be anticipated and compensated for where possible.

Short training modules were developed addressing the topics listed above and distributed to the parents.

Goal 10: To establish and/or expand programs so that each youth in the target population will have access to appropriate pre-vocational and vocational training experience, and/or to vocational rehabilitation evaluation, with individualized rehabilitation plan which meets his needs in order to approximate financial/social independence.

L 10.1 A documented list of all potential pre-vocational and vocational training sites available to the target population will be available.

Implementation: Possible prevocational and vocational training sites for the target population were identified through a survey in the community. (See Vocational Facilities in the Community Resources List in Appendix B.)

Contact was made with four agencies in the area to offer and arrange for inservice training for staff in anticipation of referral and acceptance of MVP clients into these programs. In some cases the offer was considered but not accepted. In one case, intra-agency problems necessitated cancellation of the inservice workshop. Extensive efforts by MVP staff revealed that making changes in the established Vocational Rehabilitation system would be extremely difficult. Locating funds for services to clients who were still in school proved to be impossible. The primary accomplishments in this area was in establishing two-way communication between school and adult service facilities to enhance continuity of service delivery.

A workshop was provided for rehabilitation personnel at Tennessee Services for the Blind. A workshop series was conducted at Impact, a multi-county training program. A workshop was conducted at King's Daughters School, a residential school for the handicapped in Columbia, Tennessee. A series of materials was prepared and distributed to vocational skill teachers in lieu of a scheduled workshop which was cancelled due to bad weather.

Informal meetings and consultation were ongoing throughout project operation with prevocational and vocational training sites. Services for the multihandicapped visually impaired are still available only on a very limited basis. Public facilities operate under rigid guidelines, and the policies and guidelines of Vocational Rehabilitation Services are also very rigid. In some cases, it was even found that placing a client under Vocational Rehabilitation might limit his vocational future rather than improve it. A client's eligibility for services could be permanently discontinued if the client did not perform according to standards in an initial trial period.

Gains were made as a result of MVP efforts in expanding communication lines between educational programs and vocational training sites. Links for referral, consultancy, and assistance in vocational evaluation and programming were established between the three adult and work activities centers in Davidson County and the educational programs. The teachers and the centers agreed to make referrals and maintain updated files on students who would be potential clients within a year. The centers agreed to send a staff member or a Department of Mental Health - Mental Retardation outreach worker to staffings at the schools during the client's last year in school to maintain communication and assure smooth post-school service transfer.

L 10.2 An individualized vocational training/rehabilitation plan will be available on every child or youth identified for service in the center project.

L 10.3 Systematic review and progress evaluation will be maintained on every child or youth engaged in a program prescribed by the project diagnostic/evaluation center.

Implementation: One aspect of the vocational counselor's job was to assist teachers in identifying and developing appropriate prevocational goals and objectives to be included in individual IEP's. These goals were reviewed as other IEP goals were.

As reported in the implementation of L 4.1, it was found to be impossible to provide a comprehensive assessment for every identified MVP client. All assessment reports included prescriptive programming appropriate for their ages and levels of development. Prevocational skills were assessed and goals, objectives, and activities to develop prevocational and vocational potential were included in the individuals' prescriptive programs. (See Prevocational Prescriptive Programming from evaluation report in Appendix E.) Formal review and updating of these goals were implemented in reassessments. The vocational counselor and diagnosticians were always available to teachers when adjustment or adaptation of goals and objectives were necessary.

The progress of two clients in the MVP prevocational training program was monitored during the last year of the project. As a result of programming and MVP negotiations one subject has been placed in a community adult work program following graduation. The other subject was placed in a work program at Clover Bottom Developmental Center where he is a resident, rather than in a general activity program as originally planned by Clover Bottom personnel.

A pilot project to test effectiveness of a vocational programmed instruction package was conducted with nine (9) MVP subjects. As a result sixteen (16) MVP clients participated in vocational training in the classroom.

L 10.4 A documented set of criteria will be available against which all future youths will be measured in order to formulate rehabilitation training programs efficiently individual.

Implementation: Teachers were provided copies of assessments used by most adult vocational training programs with adaptations of the scales for various disabilities. One of the problems MVP identified in planning prevocational and vocational training to prepare clients for acceptance by vocational facilities was that criteria to be targeted varied according to the piece and contract work available to the programs. However, there were fundamental skills and behaviors identified as necessary for success in vocational placement, regardless of the specific types of work to be performed by

the client. Prescriptive programming for prevocational and vocational included objectives in these areas: cognitive functioning, motor skills, communication skills, daily living skills, and adaptive behaviors and social skills. (See "Skills Necessary for Success in a Vocational Setting" in Appendix E.)

Goal 11: To develop a community-wide public information/public education program, to alter public attitudes, thereby increasing acceptance and active support of both government and private sectors.

L 11.1 To conduct a systematic public information/public education program with effective use of available media.

L 11.2 To package for dissemination a public information/public education program.

L 11.3 To document a list of non-productive public attitudes toward the target population.

L 11.4 To document movement of a selected sample within the target community toward productive attitudes about the target population.

Implementation: Although the originally planned strategies were not the means utilized by the project to achieve this goal, many other project activities served to accomplish this goal. The advisory council served as a dissemination of information channel to local and state agencies. Lines of communication were established for the project at the state level for reaching other regions of the state. Council members who were associated with local agencies arranged for presentations about the project and training workshops for agency personnel.

In conducting the community resources survey, widespread stimulation of awareness was accomplished among agencies who were providing services to the developmentally delayed but not to the multihandicapped visually impaired. These agencies became familiar with the MVP, and most agencies expressed an interest in serving this population. Arrangements for workshops were made, and the project addressed the specific needs and interests of agency personnel. As a direct result, attitudes toward working with the visually impaired or multihandicapped which were previously limiting services available to the population were altered, and new sources for services were established. Some agencies who were serving the population expressed some uncertainty as to the appropriateness of services and requested specific training to refine the services previously offered. (See Dissemination and Marketing Activities section in Appendix D for specific listing of these efforts in the Nashville and surrounding areas.)

As the public school system is not required to serve pre-school children below the age of 4, the Infant/Toddler teacher contacted day care and educational programs whose handicapped population included this age group. Several of these agencies had not previously

accepted multihandicapped or visually impaired children into their programs. Through negotiation and consultation, several of these agencies accepted individual MVP clients. The success of this MVP/agency cooperation in planning and implementing programs for these children is facilitating more positive attitudes on the part of those agencies regarding their capabilities of serving this population effectively. The children are being successfully integrated into these programs.

Through the efforts of the vocational placement counselor and MVP teachers, vocational placement for two clients has been arranged with agencies who were previously hesitant about working with or employing this population. One client will be working part time as an aide in a day-care center, and the other client has been placed at an adult vocational and independent living training center which had never accepted visually impaired clients.

Brochures identifying the MVP and its intent to share materials and provide workshops were distributed to agencies in Tennessee and the five surrounding states. Responses to the brochure were followed up by telephone to identify individual agency needs, and workshops were scheduled and conducted to meet these needs.

MVP developed a slide-tape presentation "Five Children Learn" for purposes of public information about the project and the effectiveness of educational/training services to the multihandicapped visually impaired. This has been presented locally for community groups and agencies as well as local college classes. The presentation has also been given at conferences and workshops throughout the country and in other countries.

MVP staff have on many occasions presented modules developed by the project in Peabody and other community colleges' classes.

Two local high schools worked with Harris-Hillman school staff in providing student volunteers to work in MVP classes. MVP provided workshops training in preparation for the practicum experience. Students from one high school had prior experience with handicapped children, while students from the other had little experience with the handicapped. Of the latter group, 67% dropped out, but the drop-out rate from the first group was negligible. Subsequent workshop content focused on attitudes toward the handicapped. As a result, volunteers from the two high schools have continued to work at Harris-Hillman and Clover Bottom Developmental Center for the last two years, and continued cooperation is anticipated.

MVP sought the assistance of a local optometrist in low vision evaluation and aids for students at Harris-Hillman. Although he had no experience with this population, he was very receptive to the idea. Through his work with the MVP, he became very interested in this population and now sees several multihandicapped patients through his practice. He recontacted the project regarding his continuing

interest in involvement with the project. He has agreed to serve on the Advisory Council for the outreach project.

In planning the public education/information strategies for the outreach phase, the project has suggested the following activities:

- 1) Development of a brochure describing the services and information available at the replication sites and the effectiveness of services for the target population.
- 2) Distribution of brochure to community agencies to stimulate awareness of the project and encourage cooperation and support for the project.
- 3) Development of a brochure describing the positive aspects of the target population, the needs and potential of the population, and the agencies which provide services or information to the population.
- 4) Distribution of brochure throughout the community to reach agents involved in the delivery of educational and training services, day care facilities, agencies offering services needed by the target population and their families, appropriate recreational facilities, medical personnel, and the general public in order to encourage positive attitudes toward providing services to this population.
- 5) Contact with church groups and civic organizations in the community to request assistance in dissemination of information for community awareness and encourage involvement with and support for the project.
- 6) Contact with local high schools (1) to determine the possibility of establishing work-study arrangements for students interested in special education, (2) to identify civic organizations which might provide assistance in a community awareness program, and (3) to discuss the possibility of making presentations at assembly programs describing the project, the population, and how students could become involved.
- 7) Contact with community senior citizens' groups to encourage volunteer help and support for the project.
- 8) Expansion of public relations through soliciting interest of local newspapers, television stations, and radio stations.

Goal 12: To expand and enrich a full range of orientation and mobility services for the target population, including consultation and direct experience in acquiring, or developing readiness acquisition of competence in use of pre-cane and cane techniques.

L 12.1 To assure that every individualized program prescription, where appropriate, will include recommendations on the development of specific orientation, pre-cane or cane techniques.

Implementation: All prescriptive programs developed for MVP clients for whom orientation and mobility programming was appropriate included recommendations for development of these skills. The orientation and mobility specialist worked with diagnostic personnel on a consultative basis during individual assessments and in developing specific recommendations. With input from the diagnostic supervisor, the Mobility Evaluation Scale was developed and is currently being evaluated in the field.

L 12.2 To provide an organized consultative/direct instruction service so that every child in the target population, as required, will have the benefit of professional mobility assistance.

Implementation: The orientation and mobility specialist provided inservice training to MVP staff, key personnel in the Nashville Metropolitan School System, and personnel at the Clover Bottom Developmental Center. Metro School and Clover Bottom personnel received extended training in order to ensure that individual orientation and mobility programs would be maintained for the students following withdrawal of MVP. Follow up activities included a period of observation, evaluation, and self-evaluation of trainees in mobility teaching. Workshop training modules and packets were prepared to ensure that this information will be available to other personnel. The orientation and mobility specialist provided workshop training or consultation on behalf of individual MVP clients in other programs.

As a result of MVP efforts, Clover Bottom Developmental Center recognized and met the need for a full-time O & M technician. Metropolitan Nashville Schools has retained a MVP-trained O & M technician as well as provided funds for part-time services by an O & M specialist for this population. Due to increased local agency awareness of the value of O & M services, there are now more certified O & M specialists practicing in the encatchment area than in the beginning of the project. Their presence and communication with the MVP specially trained personnel will help ensure continued quality O & M services to the multihandicapped visually impaired.

L 12.3 To document a suitable orientation curriculum for the target population below age five.

Implementation: An orientation and mobility curriculum is being prepared for those individuals functioning at the sensory motor and preoperational stages of development. The curriculum includes activities for the development of skills commensurate with these cognitive developmental levels. It will be distributed to programs in the Nashville area known to be serving MVP population for whom it is appropriate. It will also be disseminated with other MVP prepared dissemination materials.

L 12.4 To document a suitable pre-cane curriculum for the target population of primary school age.

Implementation: The orientation and mobility specialist prepared a precane curriculum and has included it in a booklet of readings in orientation and mobility techniques for the multihandicapped visually impaired. A programmed instruction slide-tape training module was developed for use in training personnel to implement this curriculum.

DISSEMINATION AND MARKETING ACTIVITIES

One of the primary responsibilities of this project to the target population in the catchment area and similar populations being served throughout the country is that of disseminating information about the positive aspects of the population, the effectiveness of services to the population, and the methods and techniques the project has found to be successful with the population. Through dissemination strategies the project has employed, this information has reached professionals and non-professionals on local, regional, and national levels. (See a complete listing of dissemination activities and products in Appendix D.)

Publications. At least nineteen (19) articles authored by MVP directors and staff have been published in appropriate special education, diagnostic, and psychological journals.

Multi-Media Materials. Two slide/tape programs were developed for dissemination of information and training purposes. One program has been presented at conferences throughout this country and in a number of other countries. A series of tapes and papers were prepared which address the special needs of multihandicapped children and their parents.

Presentations and Workshops. Approximately ninety (90) workshops and presentations were given which related specifically to the project, methods used by the project, and needs of the target population. MVP staff and directors have participated in a number of other presentations throughout the project period. Two main purposes were served through these participations: (1) stimulation of awareness and (2) training of personnel working with the multihandicapped. Approximately thirty-five (35) workshops and presentations were given for agencies or personnel in the project catchment area for expanding, upgrading, and maintaining services to the target population following MVP termination.

Demonstration. Numerous visitors from all over the United States and from other countries have come to observe at the MVP field sites. MVP staff have provided orientation to the project, materials, and consultation for these visitors.

Consultation. MVP directors and staff have been invited on an individual basis to serve as consultants for other teacher-training programs, educational programs initiating new diagnostic programs, educational programs serving similar populations, and programs serving MVP clients.

Dissemination. A brochure was developed to attract interest to the project with a mail-in form to request materials or workshop training. This mailer was sent to 75 agencies. A listing of all workshops with content description was sent to every agency requesting a workshop, therefore allowing the agency to plan training according to their individual needs. A number of workshops previously listed were presented as a result of these mailers.

The Advisory council served as a channel for dissemination of information for the project.

The project contacted many agencies in the catchment area to discuss the availability of services for the multihandicapped visually impaired and offer MVP assistance in developing or expanding services. Many workshops in the Nashville area were presented as a result of these contacts.

MVP Booklets. In order to make information about the specialized services and methods developed by MVP for the target population available on a wide-reaching basis, a number of booklets have been prepared for distribution. These booklets address the areas of service delivery and curricula which MVP found to be central to comprehensive, appropriate services to this severely handicapped population. MVP sought the assistance of a project at Peabody College which specializes in development, publication, and marketing of materials. A copy of each completed booklet is attached to this report.

ANCILLARY BENEFITS TO PARENTS, TEACHERS,
AND OTHER EDUCATIONAL PROFESSIONALS

Through project involvement in the community, a number of agencies, parents, teachers, and other educational professionals have received assistance, information, and informal training which was not specifically outlined in the goals and objectives of the project. The following are examples of these activities which have met individual and group needs related to involvement with the severely handicapped population.

1. The clinical teacher met with two speech teachers at Harris-Hillman School and assisted them with implementation of language training for the target population.
2. The clinical teacher assisted two teachers at Mur-Ci Home and two teachers at Clover Bottom by submitting written recommendations of suggested activities for their blind children and providing direct individual therapy for seven severely handicapped blind children.
3. Written recommendations for use by child care workers at Mur-Ci Home were submitted by the clinical teacher.
4. The home liaison teacher consulted with the teacher of a referral who attended Jones School in the Madison area of Nashville.
5. A home teacher for State Services for the Blind accompanied the home liaison teacher on five home visits and two screenings for multihandicapped visually impaired children.
6. High school student volunteers received workshop training on attitudes toward the handicapped and orientation and mobility skills for the severely handicapped.
7. Parents of children in the Infant/Toddler Program benefitted from regular contacts with ancillary personnel working in a support capacity with the classroom teacher. Training materials and parent counseling were made available.
8. The clinical teacher and home liaison teacher participated in the State Services for the Blind Parent Association and informed all MVP parents of this support group.
9. The home liaison teacher and clinical teacher participated in a joint Project Change - Model Vision Project parent advocacy group as resource personnel. The group became actively involved with the Davidson County Association for Retarded Citizens.

10. Information gathered by the home liaison teacher regarding community resources was shared with Project Change for dissemination to the parents. The community resources list was shared with a number of agencies including the Community Services Department of Clover Bottom Developmental Center and the Office of Special Education of the Cheatham County Schools.
11. Approximately 75 college students have benefitted from practicum experiences at project field sites. Approximately 65 teachers and teachers-in-training have received regular MVP workshop training through MVP involvement with Project Serve throughout the three years of operation.
12. Two members of the MVP staff did extensive investigation into possibilities for a short-term intensive training placement for a child from Cheatham County and reported the findings to the parents and the Cheatham County Director of Special Education.
13. Several members of the MVP staff provided workshops, consultation, and individual mobility training with a blind student and the staff involved with that student at Crockett Academy.
14. The clinical teacher consulted with involved teachers and resource personnel to give assistance in working with a visually impaired multihandicapped student at Wharton Jr. High.
15. A request for consultation services by an optometrist specializing in low vision and educational strategies was made by the Harris-Hillman teachers. The Home Liaison Teacher followed this up, made the contact, and made initial preparations for this activity. This included in-service training for the entire staff and individual evaluations of the students in the classes.
16. The supervisor of the Child Development Project of the Public Health Department in another region in Tennessee arranged to observe and consult with the diagnostic team. He also made arrangements for a one-day workshop to train his project staff from 10 counties to do screening and parent training for the visually impaired children, ages 0-5 years, with whom they come into contact.
17. The Shelbyville Child Development Center received training workshops in assessment, methods, and materials for use with their multihandicapped population. The arrangements were made through Community Services.

18. In the course of the BEH site visit, the parents of Project Change and MVP were given the opportunity to talk with the visitors about the projects, their concerns, and needs for services at a joint meeting with staff and administrators.
19. The Clover Bottom Developmental Center's Office of Community Awareness initiated a comprehensive plan for the provision of inservice training to over 30 agencies serving the severely handicapped in the Mid-Cumberland region. This office requested and received assistance from the MVP in the development of workshops and workshop materials on developmental assessment and programming, instructional methods and materials, and pre-vocational training.

PROGRAM EVALUATION

Two levels of evaluation were used in the center evaluation plan--product and process. Process, or formative, evaluation provided necessary data for immediate identification of a failure or less than optimal state in a service delivery function, whether in an individual child's training program, or, at the other end of the service delivery continuum, the information dissemination activities of the center. Process evaluation led to the essential information needed for achieving and maintaining optimal delivery of services on all levels of center and component program operations. Product, or summative, evaluation provided information concerning the extent to which the overall center and its individual component programs achieved or failed to achieve its stated goals and objectives. Summative evaluation provided a statement on the effectiveness of the final program product.

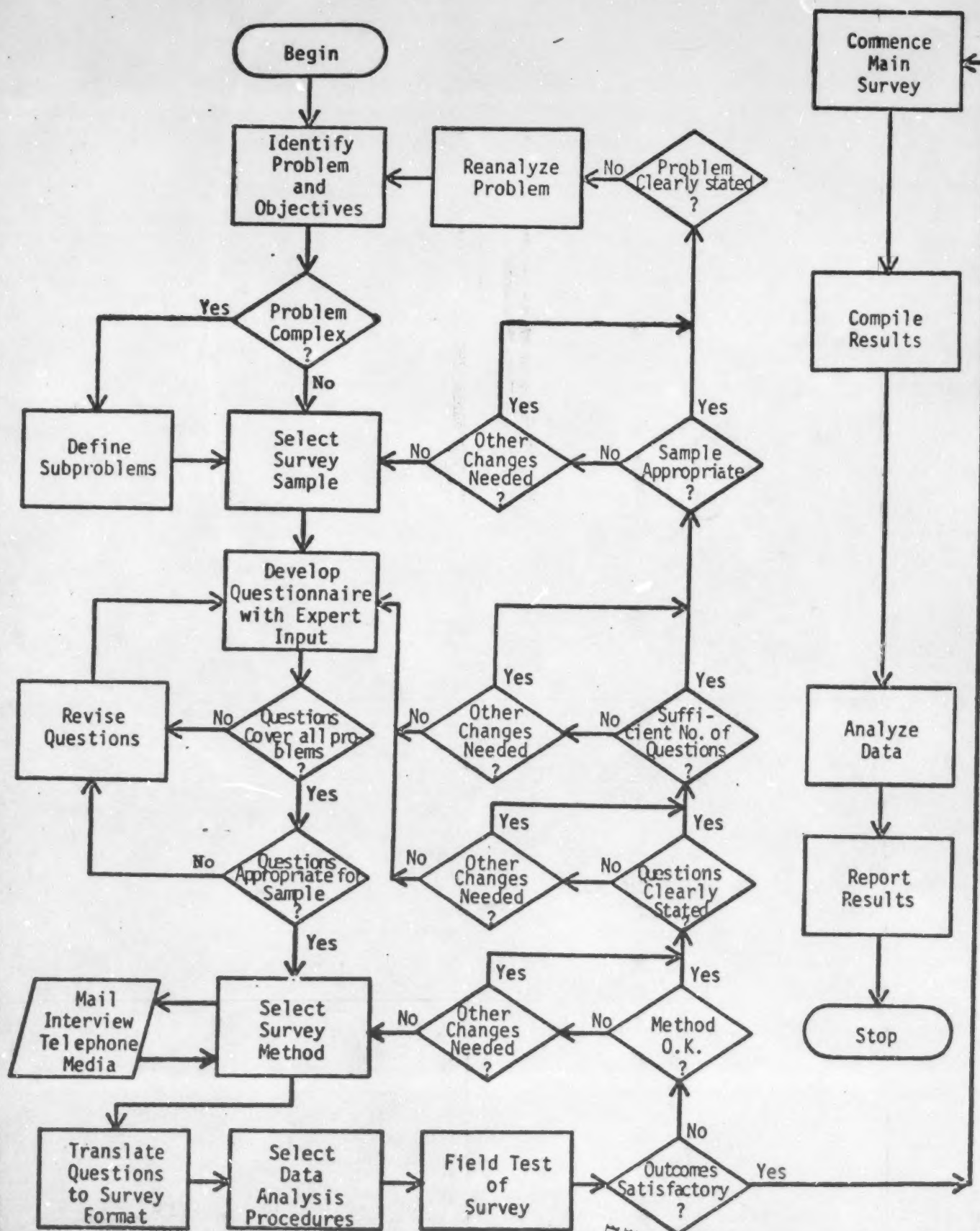
Generally, process information was provided on a micro-level (e.g., the progress of individual children) for center staff use in planning program modifications. Product information was provided on a macro-level (e.g., mean progress rate of a group of children) for federal reporting purposes.

Several of MVP Service delivery objectives over the course of the project's operation stressed the development of a process for obtaining data on the target population. A prototypic process was developed in the first year of project operation and was employed effectively for this purpose. This process which was employed in gathering data is summarized in Figure 1.

Figure 1 summarizes the sources of data, types of data, and final categories of data used for program evaluation. The overall effectiveness of the center was evaluated through a cost/benefit analysis, summary of the total number of children and families served, and additional aspects of operation such as the effectiveness of information dissemination activities, and consumer evaluation of overall service delivery effectiveness.

As mentioned previously in this report, three major service components comprised the Model Vision Project: Diagnostic Services, Field Services, and Training and Evaluation Services. The field services component was evaluated in terms of the number of children and their families receiving educational/training placements (e.g., educational, vocational), and/or ancillary services (e.g., mobility, liaison and social work services). The effectiveness of these services was evaluated through a careful monitoring of the educational/developmental progress of the children as described elsewhere in this report, and consumer evaluation of the effectiveness of the field services they received.

GENERAL PROCESS FOR OBTAINING INFORMATION ON THE TARGET POPULATION



PROGRAM EVALUATION DATA STRUCTURE

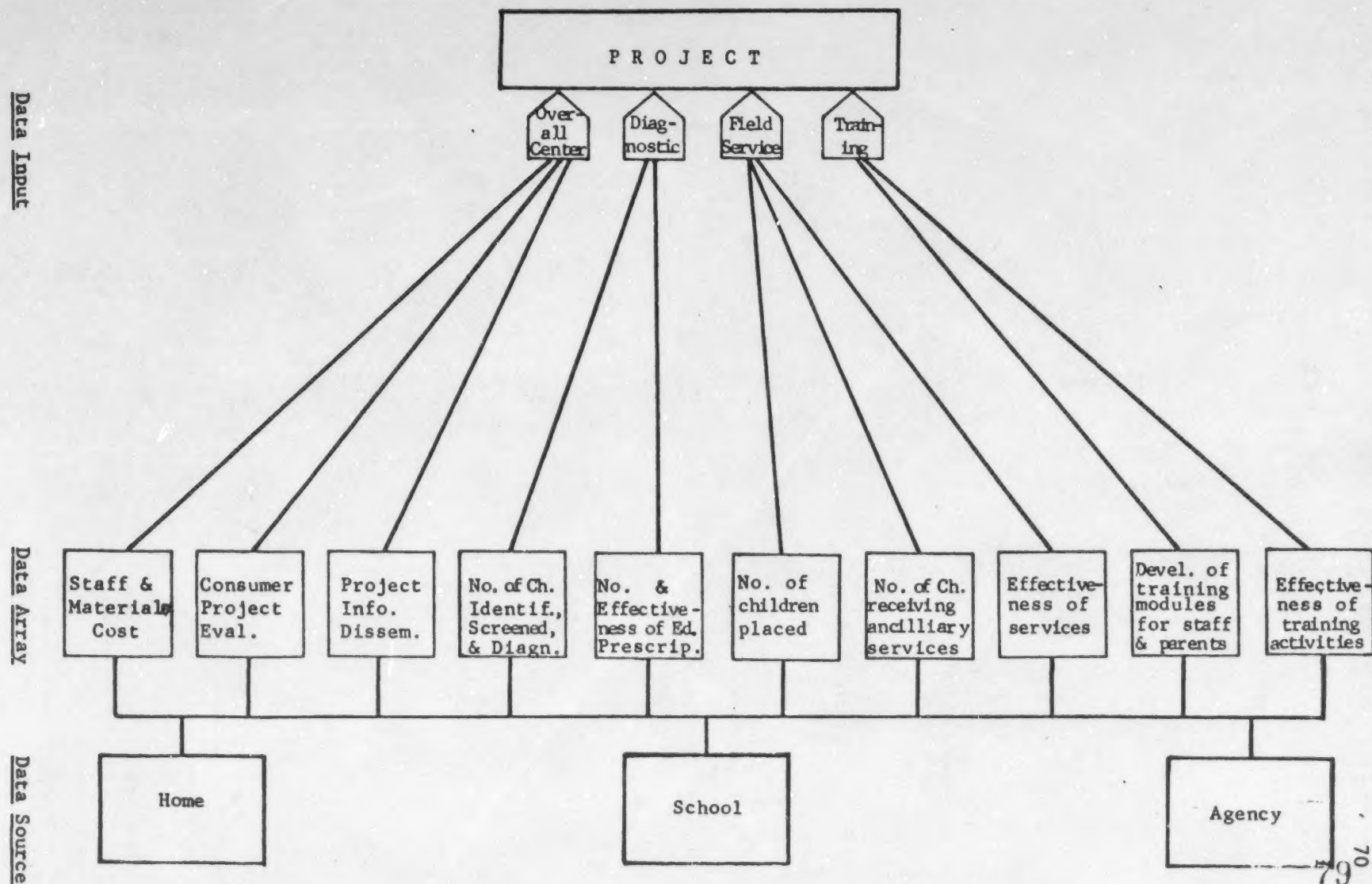


Figure 4

Utilization by classroom teachers of the educational prescriptions in actual programming was measured to evaluate the effectiveness of the prescriptions (i.e. per cent of Diagnostic Component prescriptive objectives contained in teacher constructed IEPs). In addition, consumer evaluations of the effectiveness of diagnostic services were solicited via questionnaires.

The training and evaluation component was evaluated in terms of the effectiveness of its staff and parent training activities. This evaluation was based primarily on the results of pre/post training analysis of the performance of workshop participants on criterion referenced measures.

Field Services Summative Data on Child Progress

Table 3 presents a summary of one-way analyses of variance between pre-test and post-test measures of developmental ages for 31 youngsters enrolled in either public day school programs or the infant/toddler classroom. Time constraints precluded the evaluation of all children on the MVP caseload receiving educational field services. Complete pre- and post-test measures across all developmental domains were not available for all 31 youngsters ($\bar{X}$ pretest CA = 129.9 months, $\bar{X}$ posttest CA = 150.8 months) because the nature of handicapped conditions precluded the collection of some data (i.e., wheelchair bound, hospitalization, etc.). Results of the analyses indicate that the children progressed significantly between the time of pre-test and post-test (pre-test and post-test interval = 22.33 months) across all seven developmental domains.

Such data cannot be interpreted in a causal manner, as no control group was available. A control group was not established, as the major priority of this demonstration grant was the creation and expansion of services for all eligible children within its catchment area. In addition, the diverse nature of the handicapping conditions of this low incidence population created a small likelihood of obtaining a control group equivalent to the children served by the MVP. Ethical constraints also limited the possibility of obtaining a control group within the catchment area.

A priority evaluation system was established to handle the large number of children awaiting diagnostic services. Individuals of pre-school age receiving no services received greatest priority; identified individuals of school age receiving no services were the next priority; and identified individuals already receiving educational services were last in the priority system. Deviations from the established priority system occurred in emergency situations critical for the educational placement of youngsters. Individuals not receiving direct field services (i.e., institutional residents, homebound children, etc.) did not receive intensive diagnostic services.

TABLE 3

SUMMARIES OF ONE WAY ANALYSIS OF VARIANCE OF
REPEATED MEASURES FOR DEVELOPMENTAL AGES*

Developmental Area	Pre-test Mean	Post-test Mean	N	M.S. Treatment	M.S. Error	F	P
1. Cognitive	24.10	27.20	20	94.24	19.50	4.83	.05
2. Expressive Language	19.21	24.69	31	466.13	17.24	27.04	.01
3. Receptive Language	20.95	25.79	28	327.86	24.09	13.61	.01
4. Gross Motor	16.27	19.50	20	104.83	6.88	19.50	.01
5. Fine Motor	19.65	24.29	26	279.24	16.40	17.03	.01
6. Self Care	28.83	35.55	15	245.39	21.59	11.37	.01
7. Social	30.19	35.81	16	171.13	17.66	9.69	.01

*Ages reported in months.

Developmental age data cited above were collected by MVP diagnostic team members upon the child's entry into the program. These team members are trained master's level diagnosticians supervised by doctoral level psychologists and special educators. The procedures for obtaining developmental measures have been formulated by personnel associated with this center over the last ten years. It should also be noted that screening procedures by which students were entered on MVP caseloads were not the same as those employed in developmental assessment. Screening measures included the Denver Developmental Screening Test, a functional vision checklist, and medical records.

Analyses of child progress data relied upon intra-subject analysis because of the lack of a control group. The data show a clear gain across seven developmental areas. If these children were normally developed youngsters, one could have compared their progress with established patterns of development. Typical patterns of development for these distinct children have not been established in the literature. These gains could represent "normal" maturational trends for this population. While one may hypothesize that such gains represent the typical developmental pattern for visually-impaired, severely and profoundly, multiply-handicapped children, it would be unlikely that statistical significance would have been obtained in all seven developmental domains.

It is of importance to note that statistical significance was obtained with an available pool of only 31 youngsters. This small number of subjects assures that the observed results are actual differences and not a statistical incident.

Given the thrust of the program to provide services which enhance development across all developmental domains, it is important to note that the educational services as a whole for these 31 children were relatively resistant to noise in the data. As shown on page these children varied greatly in chronological age, the nature and degree of multiple impairments, and the educational settings and teachers provided.

Formative Data on Individual Child Progress

Educational, behavioral, and developmental progress of MVP affiliated educational programs was monitored on an individual level by the use of a direct and continuous precision teaching system. This data collection system was effective for guiding educational intervention with children and minimizing wasted instructional time and ineffective individual programs. To reduce teacher time expenditures devoted to data collection activities, especially in the case of the classroom teachers, behavioral sampling strategy was employed. Children enrolled in MVP affiliated classrooms were monitored using the precision teaching system. The skill areas from which each child's targeted behavior was selected varied across children. The second strategy employed to reduce infringement on the teacher's direct teaching time by data collection activities was the use of the Peabody College special education practicum students as adjunct data collectors. The practicum students both aided teachers in collecting data and collected data on individual instruction programs they were conducting with children. Our experience with the system indicates that it was somewhat unwieldy throughout the first year of intervention. Despite the fact that practicum students were available, continuous data collection on specific skill areas across all children was difficult to collect.

Data presented below represents both precision teaching procedures and minimal assistance type data. Table 4 presents split phase analysis based on individual program data (years 2 & 3). Inspection of Table 4 reveals that several children demonstrated increases in progress rate before base and terminal phase of instructional program. Composite progress slopes of children enrolled in MVP classrooms (collected over instructional areas - year 1) are presented in Appendix F. The direction and degree of the data presented in these figures indicate that children enrolled in MVP classrooms progressed at a satisfactory rate.

Table 5 presents minimal assistance type data (year 3).

Inspection of Table 5 indicates that all but two of the target children met the criteria set by practicum students and supervisors. In all cases improvement was noted in the performance across a wide variety of tasks in three different classrooms.

TABLE 4

Summary of Split Phase Analysis for
Instructional Program Data

<u>Student</u>	<u>Program Phases</u>		<u>Program</u>	<u>Cumulative Days</u>
	<u>First</u>	<u>Second</u>		
1	2.56	2.5	Body Parts	21
2	1.51	1.5	Receptive Responding	27
3	3.22	4.43	Ball Kicking	34
4	4.43	4.5	Object Motor	15
5	.58	1.85	Picture Identification	12
6	.75	1.42	Imitates Vertical Line	8
7	.25	.22	Object Permanence	30
8	1.08	1.42	Buttoning	18
9	1.80	2.19	Signing	28
10	1.30	3.70	Block in can	18
11	2.5	3.5	Bead Locate	30
12	1.5	3.0	Bead String	30
13	1.0	3.0	Ring Locate	28
14	1.30	2.0	Peg Grasp	11
15	.20	1.3	Peg Insert	11
16	.5	.5	Ring Stack	25
17	2.0	2.5	Bead String	30
18	.51	1.0	Ring holder/locates rt. hand	28
19	2.0	3.0	Ring Stack	28
20	.5	3.0	Ring Stack	25

TABLE 5

Results of Individual Child Minimal Assistance Programs

Student	Instructional Target	Results
1.	Grasp and release	criterion reached on 4 of 5 steps
	Classification	criterion reaches on 2 of 5 steps
2.	Large buttoning	criterion reached
	Form discrimination	criterion reached
3.	Shirt folding	criterion reached on 14 of 16 steps
	Color discrimination	criterion reached on 18 of 20 steps
4.	Shoe lace tying	criterion met on 14 of 24 steps
5.	Ladder walk	criterion not met, child improved
6.	Buttoning	criterion reached
7.	Language	criterion not met, child improved
8.	Color discrimination	criterion reached on 4 of 6 steps

Diagnostic tracking forms (also employed to monitor utilization of diagnostic reports) provided further evidence of child progress. A total of 335 short term objectives were contained in the IEP of 15 children from whom parental permission was obtained for inspecting school folders.

In terms of actual child progress towards meeting these objectives, the following table summarizes the per cent of progress towards teacher set criterion of successful completion.

TABLE 6

Percent of Progress Towards IEP Objectives

DEVELOPMENTAL AREA	Less than 25% Assistance Needed	75-25% Assistance Needed	100-75% Assistance Needed
Cognitive	59%	27%	14%
Language	45%	31%	24%
Motor	43%	30%	27%
Self-care	65%	25%	10%

Consumer Evaluations of Project Services

Questionnaires pertaining to the extensiveness and quality of the MVP services were distributed to 28 families who are currently on MVP staff caseloads. Parents were asked to rate MVP effectiveness in several areas of service delivery on a 5-point scale (5 = excellent, 1 = poor). These questionnaires were distributed in January 1976 and the resulting ratings are summarized below.

Diagnostics	Rating = 4.68 (very good, excellent)
Field Services	Rating = 4.34 (very good)
Training	Rating = 4.75 (very good, excellent)

A more detailed survey was undertaken during the last funding quarter of the funding period 1976-77 and 1977-78. The same form was used for both surveys. Nineteen parents responded to the 1978 survey. Parents were asked to rate MVP effectiveness in several areas of service delivery on a 3-point scale (3 = excellent, 2 = good, 1 = poor). Parents in the 1977 survey gave an overall rating of good (mean = 2.0) for diagnostic services. Parents in the 1978 survey rated MVP diagnostic services as very good to excellent (mean rating = 2.76). Parents in both surveys reported a better understanding of their child's strengths and weaknesses following the evaluation (1977 mean = 2.63, 1978 mean = 2.9). Parents reported that written feedback was clear and easy to understand (1977 mean = 2.9, 1978 mean = 2.56). Lowest rating for diagnostic services concerned the amount of information which helped them to work with their child at home (mean rating 1977 = 1.9, mean rating 1978 = 2.0).

The overall rating supplied by parents for educational/field services was good to excellent (mean rating 1977 = 2.5, mean rating for 1978 = 2.63). Slightly less than half of the parents in both surveys reported a need for home visitation or social work services. Those who were receiving services (N = 4 for the 1978 survey and N = 2 for the 1977 survey) rated those services as very good to excellent (mean for 1976 = 2.8, mean for 1977 = 2.62). In terms of parental overall rating of MVP services received by the child and family 1977 parents rated those services as good (mean = 2.2) while the 1978 survey yielded a very good to excellent rating (mean = 2.82).

When questioned about changes and improvements parents would have liked to have seen, the following improvements were suggested: parents regarded transportation to and from school activities as a problem; several parents wanted an extension of physical services in addition to summer day school programs; and also several parents commented on the benefits they received on observing the child during the evaluation process or in working with the child in teacher and school programs. The following quotes capture the tenor of their reports, "I, myself, learned a great deal. I became aware of the little things that she does and look at her more closely now." A

majority reported they benefitted from the supportive aspect of meeting with other parents. The statement by a mother that "We no longer felt that we were the only ones with a child like ours" typifies parental remarks regarding support.

Diagnostic Services

A MVP tracking system was implemented by the diagnostician during the first quarter of the 3rd year. Implementation of this system consisted of: 1) the inclusion of copies of the MVP "Child Progress Tracking Form" (See Appendix F) with each diagnostic report completed by the Diagnostic Component, 2) completion of the tracking forms on a semi-annual basis by the children's teachers and 3) return of the tracking forms for MVP review. The tracking form data were employed to evaluate the utility of educational prescriptions as well as monitoring individual child progress.

Student progress tracking was undertaken during the first quarter of the third year of funding. Permissions to inspect the Individual Educational Programs of fifteen children were obtained from their parents/guardians. Comparisons were made between the recommendations contained in the diagnostic reports and the IEP's constructed by the teachers in four areas of educational development - cognitive, motor, self care, and language. A total of 335 short term objectives were contained in the children's folders. Overall, 70% of the short term educational goals contained in the IEP's were taken from the diagnostic reports. Inspections of the different areas of educational development revealed that 80% of the self care objectives, 73% of the cognitive objectives, 70% of the motor objectives and 70% of the language objectives were drawn from the diagnostic reports. Results of this survey indicate diagnostic reports were utilized effectively by teachers of MVP children.

Training Component

Validation of Prototypic Training Modules and Related Descriptive Materials

The development of a comprehensive system for validating MVP training modules and related descriptive materials began during the second year of project operation and continued through the third year of operation. This system consisted of three major sections including: 1) a decision map for determining the most appropriate validation method as a function of the intent and related characteristics of a given prototypic material (See Appendix F); 2) a set of guidelines for editorial evaluation of instructional modules; a set of validation procedures.

Figure 5 presents a flowchart of the validation system. Necessary forms for implementing the system were developed, and copies have been included in Appendix F. In summary, the validation system consisted of the following steps: 1) pretesting of participants using a module specific criterion referenced test; 2) presentation of the module; 3) posttesting of the participants using a module specific criterion referenced test; 4) completion of participant feedback forms; 5) completion of modules training form; 6) data analysis; and 7) module revision based on evaluative data.

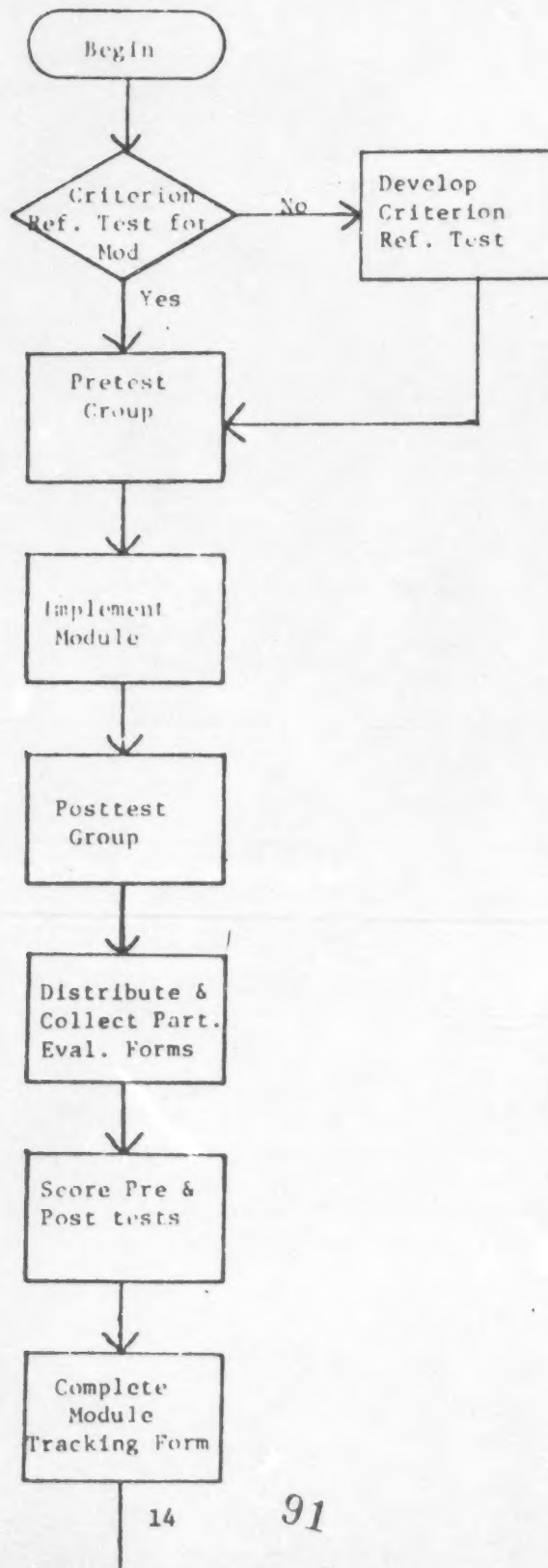
Effectiveness of Workshops and Training Modules

Formal evaluative data was collected on major MVP workshops conducted over the three years of project operation. The sites for the workshops were primarily located in the state of Tennessee and the participants ranged from teacher aides to educational diagnosticians and psychologists. The content of the workshops was focused on basic educational training principles and procedures for guiding interviews with severely handicapped, visually impaired children, diagnostic tools and procedures and managerial aspects of program developments.

Statistical analysis of participant pre-post training performance indicated that these workshops have been very effective in increasing the working knowledge of participants regarding severely impaired children.

Table 7 presents a listing of the type of participant, workshop site, and a survey of pre-post testing performance. Participant evaluation of workshops has been uniformly positive. The mean rating (4.0 scale) for the workshops listed above indicated that participants found the content of the modules useful (3.65) and the presentations clear (3.58). Attendees rated the workshops as well organized (3.75) and the materials as very helpful (3.8).

Figure 5

TRAINER
LEVEL

PROGRAM
EVALUATION
LEVEL

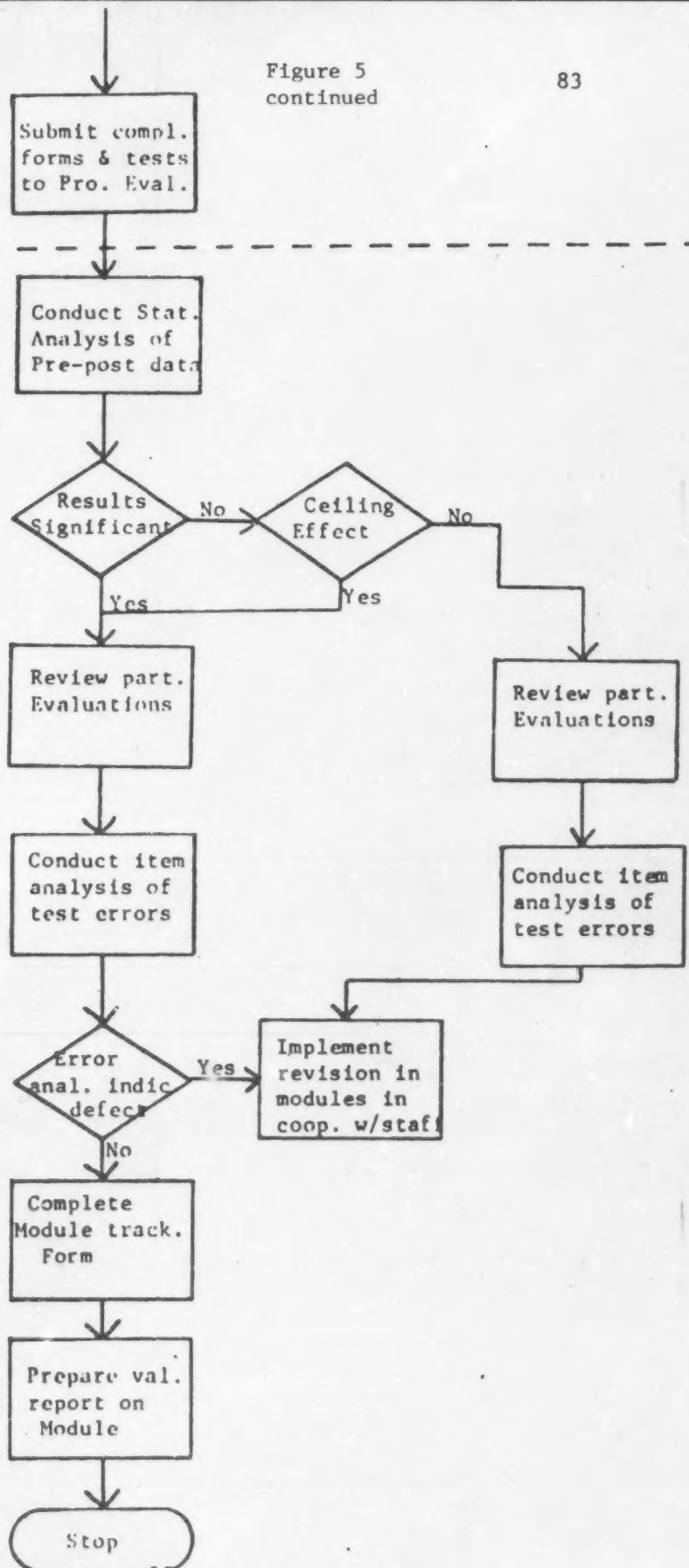


TABLE 7

Summary of t-tests for related measures for pre and posttest performance of groups participating in MVP Inservice Training Modules

Participants	Module	N	Pretest $\bar{X}$	Posttest $\bar{X}$	t
Mid-Cumberland Project SERVE Teachers	Self-Help/Mobility	19	15.68	26.79	14.33**
Developmental Training Center Technicians	Orientation & Mobility	9	1.50	10.50	9.47**
Mid-Cumberland Project SERVE Teachers	Developmental Screening	21	15.62	18.26	13.16**
Metro/Nashville School Psychologists	Developmental Assessment	16	12.00	16.5	5.79**
Region III ESC Diagnosticians Victoria, TX	Developmental Assessment	12	22.50	24.75	2.54*
Mid-Cumberland Project SERVE Teachers	Intervention Strategies	18	12.69	25.11	7.88**
Nashville Volunteer Workers	Intervention Strategies	7	16.85	19.42	2.49*
School for the Blind Teachers	Intervention Strategies	6	7.83	13.83	4.78**
Preservice Teacher Trainees	Vision Training	9	3.4	4.8	7.78**
Mid-Cumberland Project SERVE Teachers	Intervention Strategies	16	7.56	14.68	8.61**
Johnson City, TN Dept. of Public Health Personnel	Impact of sensory deficits on cognitive development. Self-help	14	6.65	18.29	6.48**
Knoxville, TN Public Health Department Child Development Specialists	Impact of sensory deficits on cognitive development. Vision Screening	35	4.08	13.74	13.60**

** $p < .01$ (two-tailed test)

* $p < .05$ (two-tailed test)

Staff Time Utilization

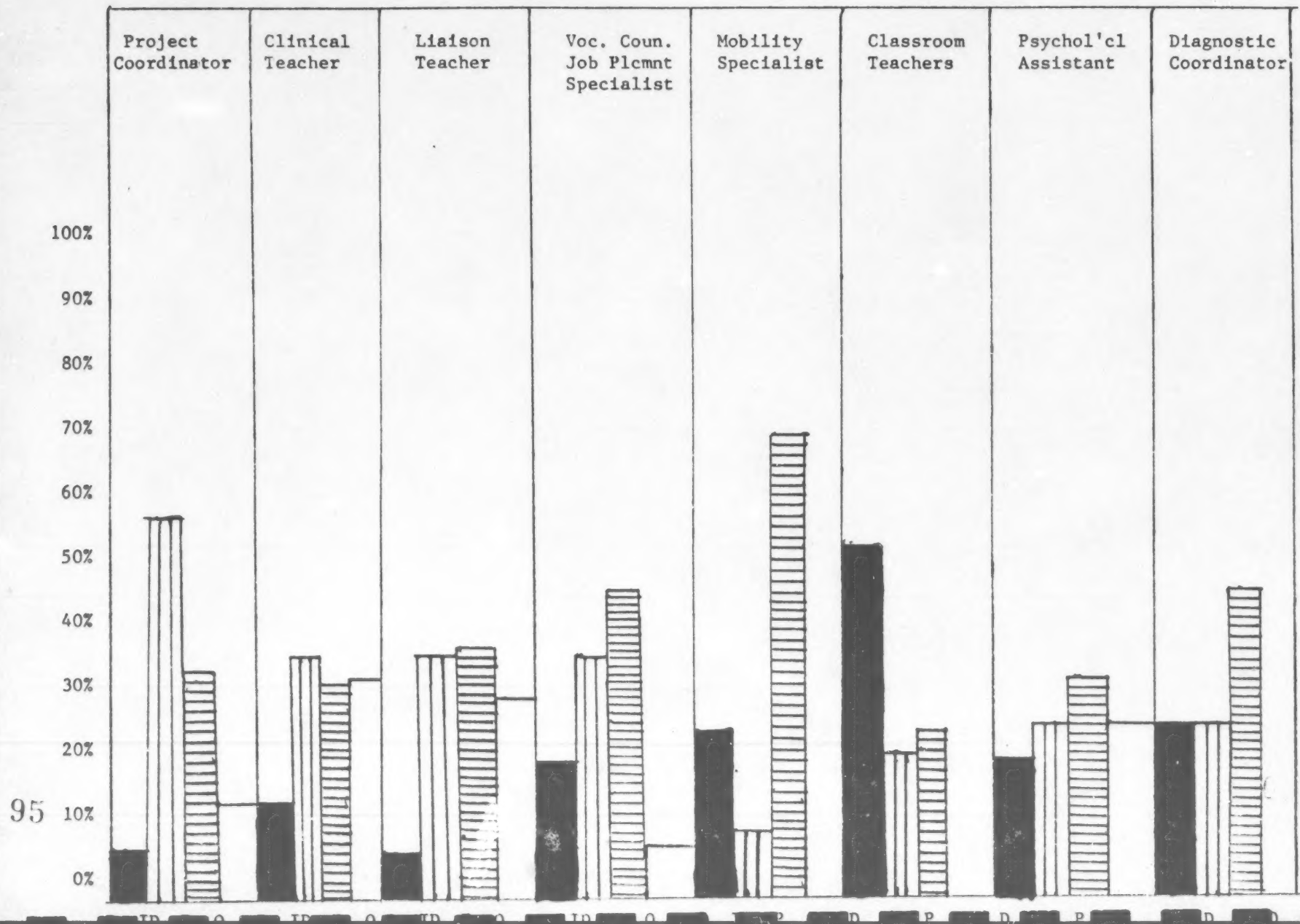
Staff time utilization sheets were completed on a monthly basis by all MVP staff members. These sheets provided a breakdown of the amount of time each staff member spent in "direct" service (time spent with parents and children), and "other" activities (professional meetings, presentations, etc.). Four categories of staff time allocation were provided for on each sheet. Category "D" (Direct Service) consisted of time expended in direct contact with children or their families (e.g. home visits by liaison teacher). The category "I" (Indirect Service) consisted of time expended in indirect service activities such as para-professional training or consultation with agency staff. The category "P" (Preparation) consisted of time devoted to preparing dissemination material, professional conferences, etc. The fourth category, other, represented activities not covered by the previous three categories. A copy of staff time utilization sheets is appended.

This staff time data was used for analysis of: 1) MVP service delivery outcomes vs. staff time if service delivery deficiencies became evident; 2) projecting staff requirements for future MVP service delivery activity; 3) monitoring takeover by community agencies of MVP direct services (i.e., as MVP phased out of direct services, the proportion of direct to indirect services should have decreased).

Figures 6 and 7 present graphs of the time each staff member devoted to various categories or levels of service. The data presented in Figure 6 were collected from September, 1977 through May, 1978. Figure 7 presents the data compiled from September, 1975 through May, 1976. The basic configuration of staff time allocation changed in the expected direction of increased indirect service time and preparation time with a corresponding decrease in Direct Service activities. The shift in the configuration of the time data resulted from change of emphasis of the project staff from direct service activities to training trainees and related personnel as well as preparation of dissemination material. As expected, no basic change occurred with classroom teachers, who continued to emphasize direct service.

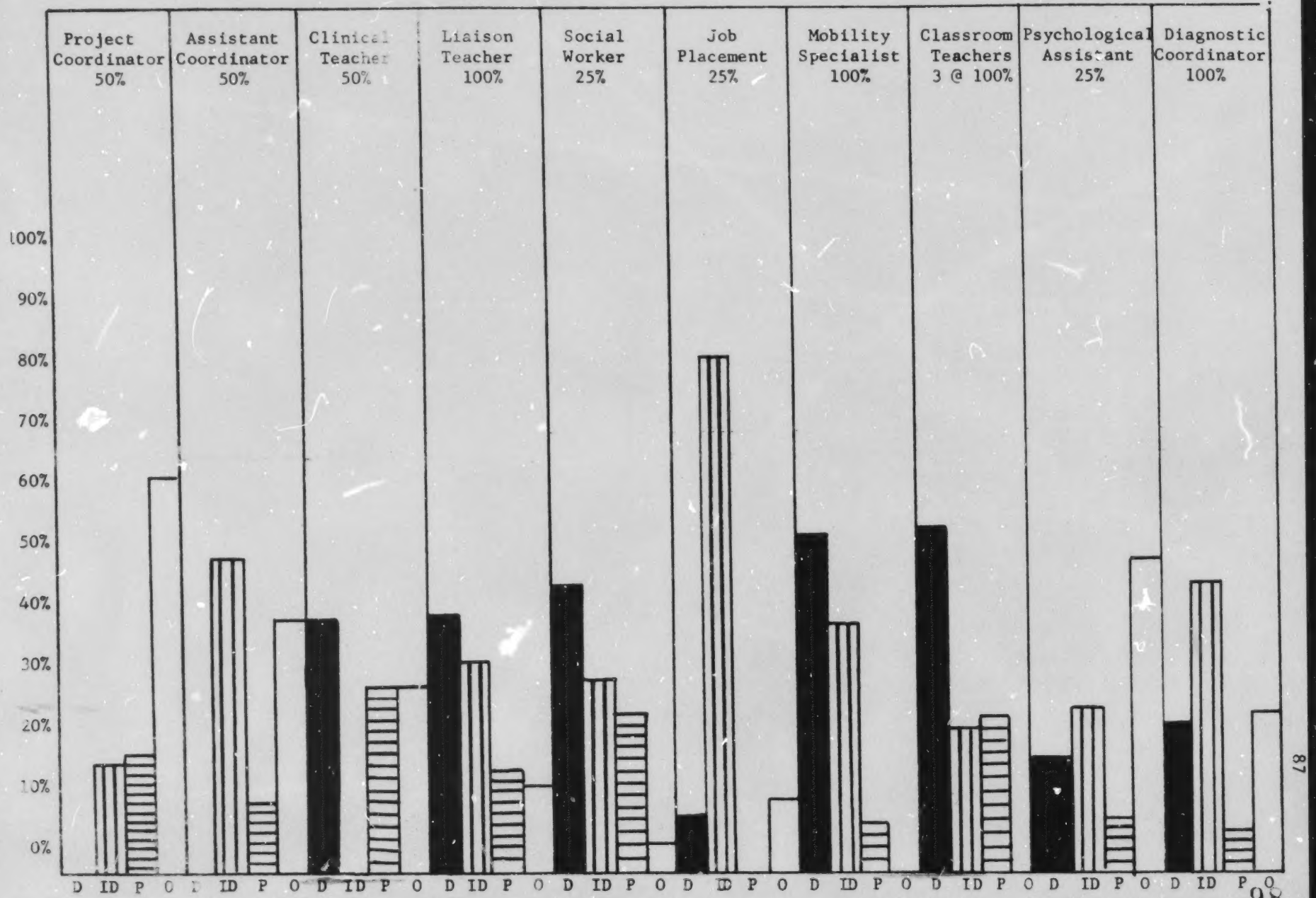
Figure 0
STAFF TIME UTILIZATION

ID - Indirect
P - Preparation
O - Other



STAFF TIME UTILIZATION

ID = Indirect
P = Preparation
O = Other



Alternate Man Power Resources

During the third and fourth quarters of the MVP's first year of operation, a study was conducted on the efficacy of using high school students as volunteer teacher aides in MVP affiliated classrooms. Undertaking this project included: (1) providing background training to the students regarding severely handicapped, visually impaired children and (2) supervising the classroom activities of the volunteers. Table 8 presents a summary of the time input--volunteer time output analysis of the project. The input category labeled "Formative" includes those staff activities which can be prorated over future volunteer training activities (e.g., training modules). The category labeled "Operational" includes reoccurring staff time expenditures per training project. The output category is presented in terms of volunteer direct contact hours with classroom children. Inspection of Table suggests that a very favorable ratio exists between staff input and volunteer output. This ratio can be expected to increase as a function of commencing training at the beginning of the school year and thus enabling the trained volunteers to work in the classrooms for a period of several months following the initial expenditure of staff training time. Teacher and school administration evaluations of the performance of the volunteers have indicated that high school students can be effectively utilized to expand direct intervention time per child. Further, several of the high school students indicated that they found the experience of working with the children rewarding and will consider special education as a future career.

TABLE 8

Time Input-Output Analysis of Volunteer Project

	<u>Input (in hours)</u>		<u>Output</u>
	<u>Formative</u>	<u>Operational*</u>	9 volunteers @ 3 hours average per week = 27 hours per 8 weeks
Liaison	12	16	
Social Work	8	16	
Mobility	2	4	
Classroom Teachers	10	16	
Totals	32	52	176 children contact hours

*Over 8 week period

PERT Analysis of Staff Time Utilization

Members of the MVP staff adapted the Program and Evaluation and Review Technique (PERT) to monitor the extent to which project staff time was used effectively (Bourgeault and Merbler, 1977). The Program and the PERT system (Federal Electric Corporation, 1963) was designed as a management tool to assist decision makers in identifying, sequencing, and scheduling activities and tasks which define a project. A relatively simple statistical model which generates probability statements regarding the initiation and completion of project activities serves as the foundation of this model.

While initially designed for planning and managing large scale projects, the PERT was adapted by Bourgeault and Merbler (1977) to apply to smaller, conceptually different "projects". By "project" Bourgeault and Merbler (1977) refer to the unique professional services any given staff member provides to one client served by the Model Vision Project. Because this approach is best applied to staff positions which can be analyzed into a set of discrete activities which are relatively stable over clients, the PERT analysis was restricted to four MVP positions, 1) Home Liaison Teacher, 2) Educational Diagnostician, 3) Psychologist, 4) Family Worker. Descriptions of these positions can be found in earlier reports.

The first step in conducting the PERT analysis of the MVP staff members consisted of interviewing staff members to determine activities involved in serving one child. The resulting list of activities for each team member is shown in Table 9. The second step consisted of having team members maintain a daily log of the time required to complete activities.

The log data were used to determine an optimistic time estimate (shortest time required to complete a given activity) a most likely time estimate (average time required), and a pessimistic time (longest time) estimate. The three time estimates associated with each diagnostic team member's activity are presented in Table 9.

The third step consisted of generating expected times and variance estimated for the completion of each diagnostic activity and total expected time and variance for each MVP staff member. The fourth step consisted of determining the total amount of professional time per month that a particular diagnostic team member had available for service activity. The fifth step consisted of the computation of a Z-score for differing caseloads and comparing these scores with a standard table of Z values to determine the probability of serving specific numbers of clients. These caseload estimate figures were obtained by multiplying the expected time and variance for serving one client by a chosen caseload number. Table 10 presents Z values and probabilities for different caseload numbers based on MVP staff members' estimates. These probabilities are best viewed as bets (Merbler & Bourgeault, 1977). That is to say that a probability represents a 50-50 chance of serving the number of clients specified.

TABLE 9

90

Model Vision Project Staff Time Logs and Estimates

MVP Staff Member	Activity	Time Log			Expected	Variance
		a	m	b		
Family Liaison Worker	Arrangements	15	30	35	28.33	11.11
	Preparation	60	90	180	100.00	400.00
	Intake Interview	60	105	120	100.00	100.00
	Observation with Parents	30	45	120	55.00	225.00
	Feedback Preparation	45	90	120	87.50	156.25
	Feedback	60	90	120	90.00	100.00
	Report Writing-Supervision	360	480	600	480.00	1600.00
total					940.83	2592.36
Psychologist	Arrangements	40	50	70	51.56	25.00
	Parent Meeting	30	60	90	60.00	100.00
	Testing Time	90	120	300	145.00	1225.00
	Scoring, Feedback preparation	60	90	120	90.00	100.00
	Staff Consult	60	150	180	140.00	400.00
	Mini-feedback	120	180	240	180.00	400.00
	Parent Feedback	90	120	180	125.00	225.00
	Write Up	120	240	360	240.00	1600.00
	Supervision	30	60	90	60.00	100.00
Correction					27.5	33.98
total					1119.06	4208.98

MVP Staff Member	Activity	Time Log			Expected	Variance
		a	m	b		
Educational Diagnostician	Classroom observation	30	120	240	125	1225.00
	Parent contact	30	120	240	125	1225.00
	Feedback	45	360	390	312.50	3306.25
	Teacher/parent consultation	20	180	480	203.33	5877.77
	Testing Time	720	900	1500	970.00	16,900.00
	Preparation	270	300	330	300.00	100.00
	Scoring	540	660	840	703.00	2500.00
	Writing	360	480	900	480.00	1600.00
	Programming	600	720	900	730.00	2500.00
	Travel	150	160	170	160.00	11.11
total					4498.83	37745.13
Liaison Teacher	Meeting with Trainer	30	45	60	45	25
	Preparation	20	30	40	30	11
	Transportation	30	60	90	60	100
	Home Visit	20	30	45	31	17
	Report Writing	15	25	40	26	17
total					192	170

TABLE 10

Z Values and Probabilities for Different Caseload Numbers
Based on MVP Diagnostic Team Member Estimates*

Position	Caseload	Z Value	Probability of serving effectively
Family Liaison Worker	4	22.76	.99
	6	9.01	.99
	7	5.09	.99
	8	2.14	.98
	9	-.14	.44
	10	-1.97	.02
Psychologist	6	4.33	.99
	7	1.24	.89
	8	-.37	.35
	9	-2.86	.002
Educational Diagnostician	1	20.08	.99
	2	-1.538	.06
	3	-8.74	.0001
Liaison Teacher	19	+2.22	.986
	20	+1.38	.919
	21	+ .61	.725
	22	- .08	.460
	23	- .72	.242
	24	-1.30	.097

*Estimates based on full-time positions (8400 minutes per month).

Costs

A principal goal of the MVP was the coordination of existing community resources into a comprehensive service delivery system for target children. Since children on the MVP caseload receive differential services from several agencies on the basis of identified needs, a precise statement of the average cost per child incurred through MVP operation is precluded. However, an estimate of service delivery cost can be obtained through an analysis of monetary expenditures for different types of services, and the source of services, (i.e., direct MVP staff intervention and/or indirect service through personnel trained by staff). This estimated service delivery cost is contained in Table 11. This estimate was based on the first year of operation of the MVP.

Cost breakdown of third year activities is presented in Table 12. Comparison of the two tables indicates per child expenses were higher in the final year of MVP operation. This higher cost per child figure is related to the fact that MVP staff members devoted greater proportions of their time to dissemination and community takeover activities than in previous years when direct service activities were emphasized.

Table 13 presents a summary of the sources of levels of funding for the MVP over its three years of operation.

TABLE 11

COST INFORMATION PER LEARNER¹

<u>Service</u>	<u>Implementer</u>	<u>Number of Children</u>	<u>Block Cost</u>	<u>Cost per Child per School Year</u>
Screening	Liaison Teacher Diagnostics	88	\$1,761.76	\$20.00
Diagnostic & Prescription	Diagnostic Coordinator Psychological Assistant Ophthalmologist	30	\$8,079.90	\$270.00
Field Service (Educational)	Teachers (4)* Aides (3)	28	\$53,550.00	\$1,912.00
Field Services (Support) (Mobility, Social Work, Job Placement, Liaison, Clinical Teaching, Administration of MVP)	Mobility Specialist (50%)** Liaison Teacher (60%) Clinical teacher Social Worker Job Placement MVP Administration	88	\$51,022.00	\$579.00
Mobility	Mobility Specialist (50%***)	12	\$6,000.00	\$500.00
Liaison (Home Teaching)	Liaison Teacher (40%***)	17	\$3,600.00	\$211.00

¹ All monetary expenditures are for manpower only with the exception of the "field services--support" category which includes expenditures for supplies, travel, and consultants prorated over the 88 children, (as a total expenditure of \$8,200.00). The resulting cost per child for the support category is a very conservative estimate given that many children enrolled in the various agencies where staff training has occurred will benefit indirectly from this MVP training activity. Figures are based on funding period 1975-1976.

*MVP affiliated classrooms.

**Percentage of staff member's time devoted to training or agency consultation.

***Percentage of staff member's time devoted to direct service to children.

TABLE 12

COST INFORMATION PER LEARNER¹

<u>Service</u>	<u>Implementer</u>	<u>Number of Children</u>	<u>Block Cost</u>	<u>Cost per Child per School Year</u>
Screening, Diagnostics, & Prescription	Diagnostic Coordinator Psychological Assistant Educational Evaluator	31	17,383	575.42
Field Service - Education	Teachers (4)* Aides (3)	32		1,900.00 (est.)
Field Services Support	Vocational (50) ** Mobility (75) Clinical Teacher (50) Home Liaison Operating Expenses Administration	115	81,822.03	711.49
Mobility	Mobility (25) ***	5	3,762.75	752.55

¹All monetary expenditures are for manpower only with the exception of the "field services--support" category which includes expenditures for supplies, travel, and consultants prorated over the 115 children (as a total expenditure of \$6,093.00). The resulting cost per child for the support category is a very conservative estimate given that many children enrolled in the various agencies where staff training has occurred will benefit indirectly from this MVP training activity. Figures are based on funding period 1977-1978.

*MVP affiliated classrooms.

**Percentage of staff member's time devoted to training or agency consultation.

***Percentage of staff member's time devoted to direct service to children.

TABLE 13

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SOURCES & LEVEL OF FUNDING FOR MVP

	INSTALLATION (Non-recurring Costs)	SUBSEQUENT YEARS (Recurring Costs)		TOTAL
	1975-76	1976-77	1977-78	
Personnel	94,017	101,557	109,577	305,151
Personnel Training	1,400	650	300	2,350
Facilities				
Equipment & Printing	1,900	1,198	1,546	4,644
Consumables	4,300	1,978	1,700	7,978
Other Costs - Specify:				
<u>Travel</u>	2,700	2,530	2,150	7,380
<u>Communication</u>	443	700	700	1,843
Indirect Cost	23,754	30,573	41,639	95,966
TOTAL----	128,514	139,186	157,612	425,312

Other Evidence for Project Effectiveness

One measure of the overall effectiveness of MVP operations is the number of new services now in place for this population since the inception of the project. One of the most successful aspects of MVP was the creation of a service delivery system for an unserved population. Prior to the onset of MVP, no public school classrooms existed for the present target population. After the first year of MVP operation, the public school system fully funded the operating expenses of three MVP classrooms. Services for the Blind, a Nashville based agency, has created a half-time home teacher position to serve the multihandicapped.

In addition, MVP has had an impact upon the residential training center for the developmentally delayed. This facility has hired a full-time mobility technician (trained by MVP staff). This mobility technician provided training in orientation and mobility techniques for approximately 200 staff members. A mobility technician has been employed by the local public school system during the third quarter of the final grant period. As was the case with the residential facility, no such services had been previously available in the public school setting.

While no single agency adopted the infant/toddler program, at least three community based early childhood programs began to admit multiply handicapped visually impaired children into their programs. These organizations' decision to admit our target population may not be a direct result of the presence of the Model Vision Project, but liaison work by MVP staff and inservice training made available to these agencies are considered by the MVP to be crucial factors in these agencies acceptance of these children.

Requests for demonstration of MVP techniques continue to come in from new programs in the Nashville area. For purposes of ensuring maintenance of services, MVP is complying with these requests.

The results of the PERT analysis indicated that relatively modest increases in caseload numbers dramatically altered the likelihood of serving this population of children adequately. This was particularly the case with the intensive level of diagnostic/prescriptive services. These figures should be viewed with caution as they are based on only one case per staff position.

As a function of these results several suggestions were put forward to streamline the diagnostic process. They included: 1) adding additional diagnosticians and paring family worker and psychologist positions, 2) having the family worker and psychologist positions assume some of the educational diagnostician's responsibilities, and 3) revision of inhouse procedures to lessen the time consumed by case preparation, report writing and programming activities which according to table 9 consumed considerable time.

These results also have implications for service providers who intended to replicate these intensive level of diagnostic/prescriptive services to severely/profoundly handicapped children and youth. These results suggest that traditional caseload numbers for public school systems with diagnostic teams will probably have to be lowered when serving this population.

APPENDIX A

1. Assessment Instruments Used With Severely Handicapped Children
2. Educational Assessment

ASSESSMENT INSTRUMENTS USED WITH
SEVERELY HANDICAPPED CHILDREN

Beth Langley, M.A.
Model Vision Project
George Peabody College

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100 Boehm Test of Basic Concepts	K-first grade	Screening	Assesses beginning school children's knowledge of frequently used basic concepts essential to success in first grade. Consists of 50 items concerning the child's understanding of space, time, and quantity.
The Psychological Corp. 4040 Harry Hines Blvd. Dallas, Tx. 75235			
Basic Concept Inventory	K-first grade	Screening	Consists of 10 picture cards. Assesses not only basic language concepts, but also auditory discrimination, sequencing, and expressive language.
Follett Publishing Department DM 1010 W. Washington Blvd. Chicago, Il. 60607			
Denver Developmental Screening Test	Birth-6 years	Screening	An individually administered screening inventory designed to identify children with developmental delays. Measures four aspects of functioning: adaptive, fine and gross motor, language and personal social development.
LADOCA Project and Publisher Foundation Inc. E. 51st Ave. & Lincoln St. Denver, Co. 80216			
Developmental Activities Screening Inventory	6-60 months	Screening	A teacher administered screening instrument to determine general cognitive-adaptive functioning levels, accompanied by developmental activities suggestions.
Teaching Resources 100 Boylston St. Boston, Ma. 02116			
Developmental Profile	Birth-11 years	Screening	Inventory of skills designed to screen child's development in five key areas of physical age, self-help age, social age, academic age, and communication age. Provides individual profile depicting developmental age levels.
Psychological Development Publications, P.O. Bx 3198 Aspen, Co. 81611			

Developmental Screening Inventory	4 weeks-18 months	Screening	Consists of items selected from Gresgell Developmental Scales
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Department of Pediatrics
Albany Medical College
Albany, N.Y. 12208

Haeussermann's Developmental Potential for Preschool Children	2-6 years	Screening	An instrument designed primarily for cerebral palsied children as an assessment of cognitive abilities. Materials include objects from child's everyday environment.
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Grune & Stratton
757 Third Ave.
New York, N.Y. 10017

Lexington Developmental Scale	Birth-6 years	Cognitive, Language, Motor Personal-Social	Series of teacher administered scales divided into two groupings: infant scales that assess motor, language, personal-social, cognitive and emotional areas. The second series assess children from 2-6 years in areas of gross and fine motor, perceptual motor, receptive and expressive language, classification, personal-social, cognitive and emotional areas.
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UCP of Bluegrass, Inc.
Child Development Center of U.C.P.B.
P.O. Box 8003
465 Springhill Dr.
Lexington, Ky. 40503

Preschool Attainment Record	Birth-6 years	Screening	A general screening instrument which assesses the child's development in locomotion, fine motor skills, language development, self-help skills, socialization, and cognitive development. Primarily an interview scale.
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American Guidance Services
Publishers Building
Circle Pines, Mn. 95014

Bayley Scales of Mental Development	Birth-30 months	Cognitive	Similar to Cattell although much better standardized and reliable. Also contains motor and social scales.
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The Psychological, Corp.
4040 Harry Hines Blvd.
Dallas, Tx. 75235

102	Cattell Infant Intelligence Scale The Psychological Corp. 4040 Harry Hines Blvd. Dallas, Tx. 75235	Birth-30 months	Cognitive Development	Instrument consisting of many manipulative items used to assess the child's abilities in problem solving, imitation object permanence, object concept, and language skills.
	Koontz Child Development Program Psychological Services 12031 Wilshire Blvd. Los Angeles, Ca. 90025	1-48 months	Cognitive, Language, Motor Personal-Social	A behavior rating scale administered by parents, teachers, or therapists during child's normal activity. Establishes level of functioning in gross and fine motor, social, and language skills. Text presents developmental activities appropriate for use with hearing and vision impaired children.
	McCarthy Scales of Children's Abilities The Psychological Corp. 4040 Harry Hines Blvd. Dallas, Tx. 75235	2½-8½ years	Cognitive	An instrument to measure general cognitive functioning as well as the child's strength and weaknesses in verbal and perceptual performances. Quantitative, memory, motor development and laterality skills are also examined.
	Merrill-Palmer Scales of Mental Development Stoelting Company 1350 S. Kostner Ave. Chicago, Il. 60623	18-71 months	Cognitive Development	The scales assess not only the child's cognitive abilities but expressive and receptive language and fine and gross motor skills. Comprised largely of performance items, some of which are timed. Provision is made for a child's refusal of an item.

104	Ordinal Scales of Psycho- logical Development Uzgiris, I. C. & Hunt, J. McV., <u>Assessment in infancy:</u> <u>Ordinal scales of psychological</u> <u>development.</u> Urbana, Ill.: University of Illinois, Press, 1975	Birth-24 months	Cognitive Development	Series of six ordinal scales based on Piagetian observations of sensory-motor schemas. Concerned with the hierarchial interrelationship of achievements at different levels. Six scales include visual pursuit and the permanence of objects, the development of means for obtaining desired environmental events, development of vocal and gestural imitation, development of schemas for relating to objects, development of operational causality, and the constructio of object relations in space.
	Pictorial Test of Intelligence Houghton-Mifflin 666 Miami Circle N.E. Atlanta, Ga. 30324	3-8 years	Cognitive Development	Instrument used in assessing the general intellectual level. In order to respond the child need only be able to hear simple verbal instructions and to respond to visual stimuli. Subtests cover areas of picture vocabulary, form discrimination, information and comprehension, similarities, size and number, and immediate recall.
	Laura Lee's Developmental Sentence Types See below	Pre-syntactic formations	Language Development	Analyzes children's spontaneous speech into the early developing pre-syntactic structures based on single and two word combinations, and elaborated constructions.
120	Laura Lee's Developmental Sentence Analysis (Scoring) Lee, L.L. <u>Developmental</u> <u>sentence analysis.</u> Evanston, Ill.: Northwestern University Press, 1974	2-8 years	Language Development	Analyzes children's spontaneous speech samples into eight major syntactic categories to derive a sentence score comparable to normal language development.
				121

105	Meeting Street School Gross Motor Developmental Evaluation Battery	Birth-3 years	Motor Development	Assesses gross motor skills in supine, prone, and erect postures, visual motor integration and perceptual motor skills.
			Language Development	Assesses nonverbal communication abilities, and receptive and expressive language skills.
	Preschool Language Scale Charles Merrill Publishing Co. 1300 Alum Creek Dr. Columbus, Oh. 43216	18-84 months	Language Development	Designed to isolate areas of strengths and weaknesses with regard to language facility. Consists of auditory comprehension and verbal ability scales as well as an articulation screening section.
	Receptive-Emergent-Expressive-Language Scale Anhinga Press 550 Park Ave. East Tallahassee, Fl.	Birth-36 months	Language Development	Primarily an interview scale, the REEL assesses the child's comprehension and expression of early language skills. The scale reveals any differences that may exist between the infant's CA and his combined receptive-expressive age.
	Receptive Expressive Language Assessment for the Visually Impaired Ingham Intermediate School District 2630 West Howell Road Mason, Michigan 48854	0-5 years	Language Development	Assesses receptive and expressive language of children who are visually handicapped. Items have been adapted to the auditory and tactual modes. Taps morphological, semantic, and syntactic structures.
	Environmental Pre-Language Battery	Early Language Development	Language Development	Designed for use by parents, paraprofessionals and teachers in the assessment of the child's comprehension, verbal and gestural imitation ability and expression of one and emerging two-word constructions.
122	The Nisonger Clinic Ohio State University 1580 Cannon Drive Columbus, Ohio			

106

Environmental Language Inventory

The Nisonger Clinic
Ohio State University
1580 Cannon Drive
Columbus, Ohio

One and two word
utterance level

Language
Development

Intensive assessment of the child's application of semantic grammatical rules in two and three word utterances. The child's expressive language is assessed in imitation, conversation, and play as he is provided with contextual and non-linguistic cues.

GATE

Box 158
Peabody College
Nashville, Tn. 37203

Birth-3 yrs.

Language
Development

A nonverbal scale designed to assess the manual and gestural communicative attempts of multihandicapped children

Inner Language Scale

Bpx 158
Child Study Center
Peabody College
Nashville, Tn. 37203

Birth-24 months

Language
Development

The way in which a child responds to objects and environmental stimuli is assessed on this scale based on Piagetian theory.

Test for Auditory Comprehension

Learning Concepts
2501 W. Lamar
Austin, Tx. 78705

3-7 years

Language
Development

Measures auditory comprehension of language structures and permits assignment of the child to a developmental level. Performance of items requires only a pointing response and scales assess morphology, semantics, and syntax.

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Bayley

The Psychological Corporation
4040 Harry Hines Blvd.
Dallas, Tx. 75235

Birth-30 months

Motor
Development

Assesses gross and fine motor skills of infants. Provides developmental age levels for skills such as head control, sitting, standing, walking, balance, climbing, jumping, and visual-motor integration.

125

107 Cerebral Palsy Assessment Chart Semans, et. al. <u>Physical Therapy</u> , 1965, <u>45</u> , 463-468	Reflex level- walking	Motor Development	Chart from which the cerebral palsied child's postural control may be assessed for the purpose of rehabilitative planning. The level which should next be emphasized is indicated in the scale.
Fiorentino Reflex testing methods for evaluating CNS Development Springfield, Il.	Reflex level- walking	Motor Development	Provides guidelines for looking at reflexive behaviors in children. Photographic examples are included within the text of normal and abnormal reflex development.
Frostig Movement Skills Battery Consulting Psychologists 577 College Ave. Palo Alto, Ca. 64306	6-12 years	Motor Development	An instrument designed similarly to AAU scales used in public schools to assess physical development. Items of gross and fine motor development contain tasks requiring speed, accuracy, endurance, balance, coordination, and flexibility.
Fokes Stephens, W.B. <u>Training the Developmentally Young</u> , John Day, 1974	Birth-7 years	Motor Development	Provides height, weight, and characteristic behaviors of children of each level assessed. Assesses skills of upper and lower extre- mities such as locomotion; climbing, jumping, balance, reach, grasp, release, manipulation, throwing, writing, and perceptual-motor abilities.
126 Peabody Developmental Motor Scales Monograph #25 IMRID publications George Peabody College Nashville, Tenn. 37203	Birth-7 years and Birth-6 years	Motor Development	An instrument for use in assessing gross and fine motor development. The scoring section allows the child credit for minimum success rather than a pass or failure. The scales are accompanied by developmental activities for each area assessed.

Adaptive Behavior Scales

Preschool-
Adult

Social
Development

American Association on
Mental Deficiency
50201 Connecticut Ave N.W.
Washington, D.C.

Social scale standardized on mentally retarded children; divided into two sections: independent functioning and aberrant behavior. Criterion referenced checklist is most helpful in determining whether a child has coping skills to exist outside an institutional setting.

Cain-Levine Social
Competency Scale

5-13 years

Social
Development

Consulting Psychologists
577 College Avenue
Palo Alto, Ca. 64306

Standardized on a group of mentally retarded children. Information gathered based on that obtained from primary caregiver. Five major areas assessed: self-help initiative, social skills, communication, and a total global functioning score.

Lakeland Village Adaptive
Behavior Grid

Birth-16 years

Personal-
Social

Lakeland Village
Medical Lake, Wa. 99022

Allows the evaluator to derive developmental levels for areas such as eating, grooming, dressing, mobility, recreation, socialization and behavior control, all of which are task analyzed.

Maxfield Buchholz Scale of
Social Maturity for Pre-School
Blind Children

Birth-6 years

Social
Development

American Foundation for
the Blind, Inc.
15 West 16th St.
New York, N.Y. 10011

Adaptation of the Vineland Social Maturity Scale for blind children. This scale of social development evaluates children in areas of general motor development, dressing, eating, locomotion, socialization, communication, and occupation.

109	TMR Performance Profile Educational Performance Associates 563 Westview Avenue Ridgefield, N.J. 07657	Moderate to Severe	Personal-Social	Instrument which assesses self-care, safety, social behavior, communication, basic knowledge, practical skills, body usage, and health on a criterion referenced scale. Designed to aid teachers in comparing students performance against specific developmental items.
	Vineland Scale of Social Maturity The Psychological Corporation 4040 Harry Hines Blvd. Dallas, Tx. 75235	Birth-25 years	Social Development	Assesses the child's general skills in self help areas, occupation, self management and social maturity and communication. Information acquired primarily from primary caregiver.

Addendum

110	BOEHM and Tactile Test of Basic Concepts The Psychological Corp. 757 Third Ave. New York, N.Y. 10017 and American Printing House for the Blind 1839 Frankfort Ave. Louisville, KY	Kindergarten through 2nd grade	Screening	Assesses beginning school children's knowledge of frequently used basic concepts essential to success in an academic setting. Consists of 50 items concerning space, time, and quantity. Recently adapted for totally blind children.
	Blind Learning Aptitude Test University of Illinois 702 Race St. Urbana, Ill. 61801	6-16 yrs.	Cognitive Development	Tactual test for blind children that is designed to assess processes and operations necessary to learning. Stimulus materials are not verbal in nature nor are verbal responses required. The test items are in bas-relief form, consisting of dots and lines. The child does not need to know braille to take this test.
	Detroit Test of Learning Aptitude Bobbs-Merrill Company, Inc. 4300 W. 62nd St. Indianapolis, Ind. 46206	3-17 yrs.	Cognitive Development	A series of subtests which allow the examiner to assess the child's visual, auditory, and cognitive thought processes in order to pinpoint specific learning deficits. (select subtest according to handicapping condition)
	Haptic Scale of Intelligence Psychology Research Box 14 Technology Center Chicago, Ill. 60616	16 yrs.-- adulthood	Cognitive Development	A tactual adaptation of the WAIS.

Illinois Test of Psychol-
inguistic Abilities

2½-9½ yrs.

Language
Development

This instrument yields a diagnostic picture of the child rather than an I.Q. Probes the child's abilities to use language processes on a receptive and expressive basis. Purpose of the test is to detect specific learning disabilities basic to learning disorders. (select subtests according to handicapping condition)

University of Illinois
Press
Urbana, Ill. 61801

Sequenced Inventory of
Communication Development

4-48 mos.

Language
Development

Comprehensive scale of receptive and expressive language development. The SICD surveys awareness, discrimination, understanding, imitation, responsiveness and spontaneous language production. An articulation scale is also provided. This test is completely adaptable to totally blind children.

University of Washington
Press
Seattle, Wash. 98105

Stanford Functional
Assessment Scales

Birth-10 yrs.

Motor
Development

This very detailed sequential scale offers behavioral tasks for evaluating both fine and gross motor skills. Gross motor skills include strength and coordination, locomotion, balance, eye-foot coordination, and visual motor--upper limbs. Fine motor skills include reach, carry and bilateral coordination, prehension, thumb-finger manipulation, grasp, placement, release, and eye-hand coordination, and graphics.

In Bleck, E. E. &
Nagel, D. A.
Physically handicapped
children: A medical
atlas for teachers.
New York: Grune and
Stratton, 1975.

Addendum

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BOEHM and Tactile Test of Basic Concepts

The Psychological Corp.
757 Third Ave.
New York, N.Y. 10017
and
American Printing House
for the Blind
1839 Frankfort Ave.
Louisville, KY

Kindergarten
through 2nd
grade

Screening

Assesses beginning school children's knowledge of frequently used basic concepts essential to success in an academic setting. Consists of 50 items concerning space, time, and quantity. Recently adapted for totally blind children.

Blind Learning Aptitude Test

University of Illinois
702 Race St.
Urbana, Ill. 61801

6-16 yrs.

Cognitive
Development

Tactual test for blind children that is designed to assess processes and operations necessary to learning. Stimulus materials are not verbal in nature nor are verbal responses required. The test items are in bas-relief form, consisting of dots and lines. The child does not need to know braille to take this test.

Detroit Test of Learning Aptitude

Bobbs-Merrill Company,
Inc. 4300 W. 62nd St.
Indianapolis, Ind. 46206

3-17 yrs.

Cognitive
Development

A series of subtests which allow the examiner to assess the child's visual, auditory, and cognitive thought processes in order to pinpoint specific learning deficits. (select subtest according to handicapping condition)

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Haptic Scale of Intelligence

Psychology Research
Box 14 Technology Center
Chicago, Ill. 60616

16 yrs.—
adulthood

Cognitive
Development

A tactual adaptation of the WAIS.

137

113	Illinois Test of Psycholinguistic Abilities University of Illinois Press Urbana, Ill. 61801	2½-9½ yrs.	Language Development	This instrument yields a diagnostic picture of the child rather than an I.Q. Probes the child's abilities to use language processes on a receptive and expressive basis. Purpose of the test is to detect specific learning disabilities basic to learning disorders. (select subtests according to handicapping condition)
	Sequenced Inventory of Communication Development University of Washington Press Seattle, Wash. 98105	4-48 mos.	Language Development	Comprehensive scale of receptive and expressive language development. The SICD surveys awareness, discrimination, understanding, imitation, responsiveness and spontaneous language production. An articulation scale is also provided. This test is completely adaptable to totally blind children.
	Stanford Functional Assessment Scales In Bleck, E. E. & Nagel, D. A. <u>Physically handicapped children: A medical atlas for teachers.</u> New York: Grune and Stratton, 1975.	Birth-10 yrs.	Motor Development	This very detailed sequential scale offers behavioral tasks for evaluating both fine and gross motor skills. Gross motor skills include strength and coordination, locomotion, balance, eye-foot coordination, and visual motor--upper limbs. Fine motor skills include reach, carry and bilateral coordination, prehension, thumb-finger manipulation, grasp, placement, release, and eye-hand coordination, and graphics.

Case Summary of Rhonda

Rhonda was seen at the Peabody Child Study Center by the Model Vision Project's Diagnostic Unit as a part of their services to severely handicapped children with vision as a primary handicapping condition. The evaluation took place in the Infant Class of the Kennedy Experimental School and in the individual testing rooms of the Child Study Center. Summary statements of the findings are presented below:

Parental Interview: Mrs. related a series of difficult health problems from conception through Rhonda's first year of life. The numerous medical problems have affected the family by the need to give attention to Rhonda and to provide financially for her medical needs. The family has tried to allow Shane, Rhonda's four year old brother, to participate in Rhonda's care so that he will understand the difficulties involved in her care. The parents find that Rhonda's health has now stabilized and they can now concentrate on sensory motor and communication skills so that she can begin to understand those around her. This family demonstrated considerable strength and impressed the staff with their coping skills. They seemed to have the strength needed to provide for Rhonda the support system she needs now and will continue to need in the years to come.

Psychological Evaluation: The Bayley Scales of Infant Development was used to determine Rhonda's mental development. Physical problems fall primarily into the areas of vision (Rhonda is totally blind) and in the area of vocal skills (a tracheal tube has been inserted to help her breathe). These major factors have a very definite effect on the testing of abilities during the early stages of development. For this reason, the findings of this examination are only tentative. From her performance on appropriate items, it can be estimated that her mental age is around the four month level, or around the five month level when compared to other blind children.

Educational Assessment:

Adaptive Behavior: Rhonda exhibits many of the behaviors expected of blind children. In general these skills are on a 3-4 month level when compared to normal children, but on a 5 month level for blind children.

Motor Behavior: Rhonda's gross motor skills were on a 3 month level while her fine motor manipulations were on a 6 month level.

Language Behavior: Rhonda exhibited a number of nonverbal skills suggesting she is processing and beginning to act on her environment. Her nonverbal skills were on a 6 month level while her verbal skills were on a 3 month level.

Socialization Behavior: Rhonda's interactions with others indicate her behavior is similar to a 4 month old child.

Recommendations

1. The have done a remarkable job with Rhonda during her difficult young life. They should be continually praised for this.

2. The should be encouraged to find competent individuals to care for Rhonda so that they can get out for relaxation.
3. Rhonda should be continued in her present placement.

Rebecca F. DuBose

Rebecca F. DuBose, Ph.D.
Model Vision Project
Supervisor

Parent Interview

REPORT TO: Mr. and Mrs. , parents; and to Kennedy Center Experimental School

CLINET: Rhonda

DATE OF BIRTH: 12/75

AGE: 14 months

PARENT INTERVIEWED: Mrs. Elaine

INTERVIEWERS: Katherine Teevan and Joe McLaughlin

Referral:

Rhonda has recently begun attending the Model Vision classroom of the Kennedy Center Experimental School, which in connection with the Model Vision Project, utilizes psychological and educational assessments to aid the parents and teachers in their work with the children.

Background Information:

Mrs. 's first pregnancy and birth were normal. Her pregnancy with Rhonda, however, began with toxemia in the first two months. Mrs. also developed diabetes during the pregnancy. Later in the pregnancy there was separation of the placenta from the wall of the uterus. The pregnancy was difficult and painful for Mrs. and she required frequent medical attention. Her physician encouraged her to continue working and Mrs. did so despite reservations about working held by both her and her husband. Both Mr. and Mrs. have continued to be concerned about her having worked during the pregnancy.

Rhonda was born two months prematurely. She was born with hyaline membrane and was not expected to live. Rhonda did survive the first critical period and a number of serious problems which occurred during her first year. Rhonda spent the first 3½ months of her life in intensive care at Vanderbilt University Hospital and Baptist Hospital. Mrs. reported that Rhonda's difficulties during the first 3½ months included a congenital heart defect which was corrected by surgery, several bouts with pneumonia, meningitis, jaundice which required a complete blood transfusion, development of hydrocephalus and a shunt operation to control it, and continued difficulty with the lungs and breathing. While Rhonda was in intensive care, both the came to visit her every day. This was an extremely difficult period for Mr. and Mrs.

The were aware from the time of birth that Rhonda would have difficulties but no firm statement about brain damage was made by the physicians who treated Rhonda until after Rhonda had gone home with the . At this time Mrs. was told that Rhonda was severely brain damaged.

Health difficulties continued for Rhonda during the first nine months of her life. The longest she remained at home between March and August 1976

was about two weeks. She was susceptible to pneumonia, and very weak, and required Mrs. 's constant care. In June a tracheal tube was inserted to ease Rhonda's breathing. Mrs. uses an electric air pump to suction mucus from her daughter's tracheal tube and this equipment accompanies them continually.

Mrs. reported that although Rhonda is still weak and quite small, 10 pounds and 9 ounces, her health has stabilized now and she has not been hospitalized since September.

Present Functioning:

Until making contact with the Model Vision Project recently, Mrs. had continued to perceive Rhonda as a newborn. She recently has heard various professionals comment on the significance of some of her daughter's behaviors and is beginning to recognize that she has developed beyond the newborn level, but a clear perception of Rhonda's developmental level has yet to emerge for Mrs.

The 's have not thought very much about the future. Mrs. recognizes that skills such as sitting, standing, and walking will take a long time for Rhonda to accomplish. She expressed willingness to do whatever she could to help Rhonda in her development.

Rhonda and her mother have just begun to attend the Model Vision classroom of the Experimental School. This placement seems very appropriate for Rhonda and should be very helpful for Mrs. as well. Mrs. expressed satisfaction with Rhonda's improved health during the last few months.

Present Family Situation:

Mr. has been working from 7:00 a.m. to 10:00 p.m. for five days a week since November, largely in an attempt to pay the medical costs which the family has incurred as a result of Rhonda's health problems. Mrs. continues to devote most of her time to caring for her daughter.

Rhonda's older brother, Shane, was almost 3 years old at the time when Rhonda was born. Shane spent a good deal of time with friends and babysitters while his parents were at the hospital with Rhonda. Mrs. was concerned that this would make him resentful of his sister. Shane has had some difficulty adjusting to the care that Rhonda requires but Mrs. has allowed him to participate in caring for Rhonda to a large extent and he seems to have made an adjustment to his sister. Mrs. considers Shane to be important for Rhonda. He provides a type of stimulation for his sister which is necessarily different from that provided by the parents.

Mrs. is a pleasant and energetic person and seems to cope well with the variety of emotions which she experiences. Dealing with the problems of a handicapped child has caused some stress in the family but Mrs. reported that dealing with the problems have brought her and her husband closer together.

Present Concerns:

Mrs. said that she wants to know what Rhonda is capable of doing. She also is interested in learning how she can help Rhonda in her development.

When to provide stimulation and what types of things she should do are primary concerns of Mrs. .

Specifically, Mrs. would like to see Rhonda learn to sit up, to roll over, and to eat better. At present Rhonda can sit with support, rolls over only occasionally, and has difficulty with solid foods.

Mrs. expressed enthusiasm about learning to recognize Rhonda's developmental gains.

Recommendations:

Participation in the Model Vision classroom should be of great benefit to both Rhonda and Mrs. . Mrs. 's major needs at this time are educational. If she can learn to recognize Rhonda's progress and learn specific techniques to aid her learning, her daughter's development will be facilitated and Mrs. 's satisfaction will be increased. Mrs. is quite ready to learn new ways to work with her daughter.

Both parents should be encouraged to continue to allow Shane to help with his sister. They should also be sure to recognize Shane's needs apart from the needs of Rhonda.

Mrs. 's strong affection for her daughter and her willingness to work with her will be of great aid to Rhonda.

Joe McLaughlin
 Joe McLaughlin, M.A.
 Psychological Assistant

Supervised by:

Harris Gabel
 Harris Gabel, Ph.D.
 Clinical Psychologist

Psychological Evaluation

CHILD: Rhonda

AGE: 14 months

DATE OF EVALUATION: 2/15/77

EVALUATOR: Katherine Teevan

Referral:

Rhonda was recently enrolled in the infant classroom at the Kennedy Center Experimental School and is one of the children currently being served by the Model Vision Project. The Model Vision Project utilizes periodic psychological and educational evaluations to aid parents and teachers in their work with the children.

Test Administered:

Bayley Scales of Infant Development - Mental Scale

Background Information:

Rhonda is the 's second child. Mrs. 's pregnancy with Shane, Rhonda's four year old brother, was normal. Mrs. 's pregnancy with Rhonda was a difficult one and required frequent medical attention. Rhonda was born two months prematurely and had hyaline membrane at birth. A number of serious medical problems were encountered during the first year including congenital heart defect, several attacks of pneumonia, meningitis, jaundice, hydrocephalus, and continued difficulty with lungs and breathing. Hospitalization was required for most of the first nine months of Rhonda's life. A tracheal tube is presently in place and periodic suctioning is required.

The family recently made contact with the Model Vision Project and Rhonda began attending the Infant classroom in January.

Behavioral Observations:

Rhonda, weighing about 11 pounds, has the appearance of a young infant. Her delicate features, soft brown hair, and pretty clothes combine to make her a very attractive little girl. She seemed alert throughout most of the evaluation but did fall asleep promptly after the morning's activities. She held her head up for short periods of time although the accompanying shaking indicates this is an emerging ability. She is able to sit when supported, and parts of the evaluation were conducted in this position, or while Rhonda was being held, but primarily Rhonda laid on her back on a blanket for the evaluation period.

She cried frequently during the evaluation but only for short periods. As Rhonda breathes through an opening in her neck, she is not able to communicate

verbally. She responded quite well to the examiner's attempts to quiet her and especially liked being patted on her stomach. When patted in this manner she would place her hand on the examiner's moving hand and showed some indications of purposely engaging the examiner in this patting activity. She did not seem upset by the suctioning process when her trachea needed cleaning during this period. Behaviors examined for the test were very inconsistent depending on attention and motivational factors.

Test Results:

Rhonda appears to only respond visually to sharp changes in light and therefore many items requiring vision were inappropriate test tasks. As Rhonda does not breathe through her mouth and nose she is unable to vocalize and these items were similarly considered inappropriate. It is to be noted that the number of inappropriate items limit the accuracy of an estimate of Rhonda's current developmental level.

Rhonda passed all appropriate items at the one and two month level and failed appropriate items at the six and seven month level. When compared to average children, Rhonda is currently estimated to be functioning at approximately a 4 month developmental level. When compared to average blind children, Rhonda's current developmental level would be estimated to be approximately 5 months. The specific items passed and failed at the three, four, and five month levels are listed below:

	passed	failed
3 months	reaches for ring fingers hand in play aware of strange situation (RPT) carries ring to mouth inspects own hands closes on dangling ring	turns head to sound of bell turns head to sound of rattle
4 months	exploitive paper play discriminates strangers (RPT) recovers rattle	reaches for cube picks up cube retains two cubes
5 months	lifts inverted cup transfers object hand to hand interest in sound production lifts cup with handle	reaches persistently likes frolic play reaches for second cube bangs in play sustained inspection of ring exploitive string play picks up cube deftly pulls string, secures ring

Rhonda responded readily and distinctly to a variety of sounds. She was observed to squeeze a toy to make it squeek, and would sometimes reach for objects on sound cue. She also was interested in making smacking noises with her mouth. Responding to her auditory world, Rhonda showed some awareness of ways that she can affect her environment and that she can cause certain things to happen. This is also indicated by Rhonda's responses using her tactual sense as she could consistently grope for her pacifier and bring it to her mouth, very distinctively removed a handkerchief that was placed on her face, and encouraged the examiner's patting. This interest in her environment are distinctive strengths.

Examination of the failed items reveals a relative weakness in manipulating objects. She showed less interest in examining objects with her fingers than would be expected and her grasp was a brief non-exploratory motion. It is possible that this is partly related to Rhonda's small size. Rhonda's failure to turn her head to the sound of a bell or rattle is not unusual for a blind child of her developmental level. The inconsistency with which Rhonda performed tasks is not surprising in a young child, but it does give evidence that these skills are not firmly established and some abilities at the four and five month level are more accurately viewed as emerging skills.

Conclusions and Recommendations:

Rhonda, now 14 months old, is a very attractive small child. Her history reveals that she was two months premature and that she had many serious medical problems which necessitated hospital care for most of the first nine months of her life. Many test items were considered inappropriate due to lack of vision and inability to vocalize, but her current developmental level is estimated to be approximately 4 months when compared with average children and 5 months when compared to average blind children. This represents a significant developmental delay, but because of her complicated medical history conjectures about her future rate of progress are difficult to make. It is hoped that Rhonda can be re-evaluated in a year when her rate of progress between evaluations could be assessed and a clearer perspective about her future rate of progress could be gained.

Mrs. noted that she had been viewing Rhonda as a newborn child and the love and attention which she has received in this relationship have been very important in Rhonda's development. Other family members, Mr. and Shane, are also extremely important in this regard and it is hoped that all three will continue to provide Rhonda this love and attention which has been so beneficial for her. In working with Rhonda, it will be best to view her as a 3-4 month old baby and do activities with her that are appropriate for this level. Her hearing and sense of touch can be used in a variety of ways to stimulate her and help her in learning about her world. Specific recommendations are included in the educational report.

Katherine Teevan
Katherine Teevan, M.A.
Psychological Assistant

Supervised by:

Harris Gabel
Harris Gabel, Ph.D.
Clinical Psychologist

EDUCATIONAL EVALUATION

OF

RHONDA

Rhonda was observed for two days while engaged in activities designed to elicit behaviors indicating developmental levels in visual adaptive, language, motor, and socialization skills. The purpose of the evaluation was to plan an individualized curriculum to facilitate development in all educational areas. Tools used for the evaluation were the Uzgis-Hunt Ordinal Scales, Fraiberg levels, the Receptive-Expressive-Emergent Language Scale, an experimental non-vocal communication scale, the Bayley Scales of Motor Development, the Milani-Comparetti Developmental Test, and the Lakeland Village Adaptive Behavior Grid.

Overview:

Rhonda was a 14 month old premature, visually impaired child. She exhibited a V-P shunt and an external opening from her windpipe to allow her to breathe. She was aphonic and nonambulatory. Her overall development reflected a 3 month level with non vocal communicative behaviors and adaptive skills being her most developed areas. Rhonda was very socially alert and responsive to play. Her general motor behaviors were weak although there was more strength emerging in her upper extremities.

Visual Status:

Rhonda's pupils were equally reactive to light and focusing on lights or objects was inhibited by her roving nystagmus. Rhonda shut her eyes tightly when exposed to direct sunlight. At the time of this evaluation Rhonda discriminated between light and dark indicating her vision is limited to light perception.

Observations of Adaptive Behavior:

Rhonda interacted with materials and the evaluator for approximately two hours at a time. She preferred objects emitting noise of some type but her major interest and explorations focused on her own body.

Performance with various types of sound toys revealed emerging thinking and problem solving skills. Rhonda was introduced to different toys to observe the way in which she searched for them, responded to their removal, attempted to cause events or obtain objects, imitated actions, anticipated objects or actions, understood the position of objects in space, and interacted with the toys.

When she dropped her pacifier, Rhonda tactually searched for it, persistently reaching until her fingers contacted the rubber. She knew which end belonged in her mouth and turned and manipulated it until positioned correctly. When handed only a part of objects, Rhonda

identified them by applying the appropriate action associated with each.

She reached and searched for objects she heard, usually in their general direction. She loved playing with her hands and feet but reached to take an object when it was touched to her hand. Rhonda attempted to keep toys in motion by repeating simple motor acts such as squeezing, shaking, striking, or batting. She remembered toys from one day to the next and interacted with each as she had the day before. She knew how to make the pig squeak, rattle shake, and a roly-poly toy emit music. Given objects resembling ones she had previously experienced, Rhonda attempted to operate them using the actions which had been successful with the previous toys.

On the third day of the evaluation the evaluator held Rhonda as she had when observing Rhonda's speech and language. Rhonda quieted and listened and then reached up in search of the evaluator's mouth as she had previously to feel the vibrations and lip movements. Other anticipatory reactions observed were her readying herself to be picked up and manipulating the tubing to her suction machine before being cleared of mucus.

Imitations of behaviors she performed were well developed: upon hearing someone blowing air through closed lips, Rhonda immediately imitated the sound. She approximated placing her lips together to form a /b/ sound in imitation of the evaluator after approximately 50 trials. Rhonda was encouraged to feel the evaluator's lips then her own when the evaluator was attempting to elicit vocal imitation behaviors.

Realizing what to do with different kinds of objects was Rhonda's highest ability. Given toys of a cylindrical shape, Rhonda always attempted to activate them by shaking. When a xylophone was held near her, Rhonda repeatedly struck it with a thin stick by adapting her shaking action to more of a waving one. Given soft, pliable toys, she employed two hands in her midline to squeeze the toy, pausing, then resuming her manipulation. Rhonda definitely discriminated favorite toys and objects and the soft squeeze toy was often used to calm and quiet her when crying. At one point in the evaluation, Rhonda was handed a small strand of beads. She first attempted to shake them, but when they failed to produce a sound, she immediately cast them away. She made no attempt to squeeze them, apparently realizing they did not bear the characteristics that required squeezing. Rhonda discriminated between her bottle and her pacifier, often exchanging one for the other.

Impressions:

Rhonda's performance with the majority of stimuli revealed an emerging awareness of and interest in things outside of her own body. While many of her behaviors were similar to those seen in three to four month old infants, Rhonda's execution of several of these behaviors were unusual for a blind child of three to four months. Her weakest area of thinking was imitation, a skill that develops later than other abilities in blind children. The way in which Rhonda remembered objects she did not touch, where they were in space, and how to operate them were equally developed abilities. The most advanced skill within her repertoire was her integration of memory, causality, and means-ends relationships to identify

and distinguish familiar objects and their properties in order to activate them. While her abilities spanned the range from 3 to 10 months (in comparison with other blind children) the majority of Rhonda's learning was most similar to other blind children of 5 months of age.

Observations of Motor Development:

The majority of Rhonda's motor skills were characterized by weakness. No abnormal reactions or reflexes were present but major postural reactions were lacking from her repertoire.

Observations of Gross Motor Skills:

Rhonda raised her head when on her tummy long enough to turn it from one side to the other. With much encouragement and physical prompting she raised her head and momentarily sustained the position. When placed and supported in a sitting position, her head bobbed and when pulled to a sitting position there was a slight head lag.

She turned easily from her back to her side, turning from her back to her stomach with maximum physical assistance but she extracted her arm from under her with no assistance. Mrs. reported Rhonda turned infrequently from her stomach to her back.

Rhonda pulled herself to a sitting position when raised 45 degrees from a surface. She sat momentarily with a rounded back when her arms were extended beyond her feet as she sat with her legs crossed inside each other (Tailor position). When she extended her spine she fell backwards. While she did not retain a Moro reflex neither did she exhibit any protection reactions. A Landau (arching and straightening her back when supported by her chest in the air) and righting reactions were not elicited.

Observations of Fine Motor Skills:

Rhonda evidenced a definite right-handed preference; the grasp of her right hand was more efficient and refined than that of her left. She reached unilaterally for objects, switching objects from one hand to the other and crossing them over each other in her midline.

Rhonda held an object in each hand simultaneously and while she manipulated objects with both hands simultaneously, she demonstrated the ability to operate each hand and arm independently of each other.

She demonstrated hand strength when she squeezed a rubber toy, lifted a plastic cup by its handle, and held her bottle. She grasped objects with an ulnar-palmar and a raking approach. Eye-hand coordination was emerging: she reached for and grasped objects in her midline, approaching them within close proximity.

Impressions:

Postural stability, head control, and bilateral activities were Rhonda's strengths in motor development. Locomotion skills were emerging as well as sitting abilities. Rhonda lacked righting and protection

reactions and their absence prevented independent rolling and sitting behaviors. Midline skills were well within her repertoire and reaching and grasping skills were her most accomplished fine motor abilities. She evidenced readiness to begin rolling from back to stomach, sitting propped for short periods, and grasping smaller objects. The majority of her gross motor skills were emerging onto higher levels but were most functional at a 3 month level. Fine motor skills were more advanced, functional on a six month level.

Observations of Language Development:

Rhonda's vocal chords, while intact, received no innervation and her attempts to vocalize were not audible. Once her windpipe is repaired, Rhonda's voice mechanism is expected to be functional.

Rhonda reached on sound cue and stilled at the production of musical sounds and smiled in response to vocalizations from others. She listened intently as a music box was played, reaching for its handle when the music ceased. She anticipated when her mother was about to pick her up and smiled in response to her mother's voice. She was extremely receptive to feeling speaker's mouths.

Her primary means of communicating was through body postures. She resisted objects by refusing to take them or by thrusting them away. Rhonda cried when discontented, soiled and hungry. She smiled and activated her arms and legs when happy. Rhonda understood how to cause things to happen and distinguished actions appropriate for objects. She remembered where objects were once she lost them and initiated events that were pleasurable to her. All of these behaviors are critical for her realization that she can use words and actions to convey meaning.

Impressions:

Rhonda demonstrated the cognitive prerequisites for communication. She expressed imitation, causality, means-ends relationships and object relations were all concepts within her repertoire and critical for language development. Her vocal attempts were infantile in nature consisting of guttural and emerging bilabial phonemes. Non-verbal skills were functional on a six month level while verbal skills approximated a three month level. A total communication system was recommended until she can efficiently use her voice for communicating. The use of gestures will afford Rhonda an immediate means of expressing her feelings while the verbal stimulation will enable her to store the words for the time she is ready to use them.

Observation of Socialization Skills:

Rhonda was very receptive to social approaches, particularly voices and physical contact. She evidenced no distress upon being separated from her mother or by being handled by strangers. When she became upset, patting her on the chest and talking to her appeared to calm her.

She delighted in the effects she created through motor schemas, smiling as she activated toys and repeating the pleasurable effects. Rhonda was beginning to be interested in toys and rattles but more enjoyed her interactions with people.

Rhonda also exhibited an emerging awareness of her ability to manipulate her environment by crying and resisting when she was encouraged to perform an activity that was undesirable to her. When she was left alone and the evaluator stopped forcing her to interact with the undesirable objects, the crying and resisting ceased.

Rhonda was totally dependent upon her family for all of her self care needs. She ate strained foods through an enlarged nipple but independently held her bottle. She cooperated in dressing by passively allowing herself to be dressed.

Impressions:

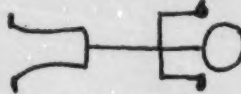
Rhonda was a very cuddly and enjoyable child who exhibited an awareness of and interest in her surroundings. She expressed definite likes and dislikes and discriminated unfamiliar people and places. She enjoyed interactions with people, particularly in the form of verbal and physical stimuli. Rhonda exhibited an emerging ability to control and actively interact with her environment and to assume some responsibility for her self-care needs. The majority of her socialization skills approached a 4 month level.

MOTOR ACTIVITIES:

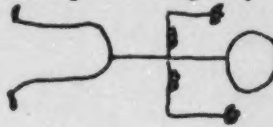
1. Purpose: To teach Rhonda head control.

Charting Behavior: When upward pressure is applied at her shoulders, Rhonda will raise her head on her tummy 90% of the time.

- A. Procedure:
1. Place Rhonda on her tummy so that her arms are bent at 90 degree angles by her shoulders.



2. Sit or kneel beside her and gently lift up at both shoulders simultaneously, placing your finger tips on her chest just slightly to either side of her neck.



3. Once she raises her head, squeak a toy or play a musical instrument above her head to encourage her to keep up her head.
4. Repeat 4 more times.

- B. Procedure:
1. Place Rhonda over a large beach ball, big enough to hold her.
 2. Put her on her tummy so that her arms are stretched out straight.
 3. Hold her at her ankles and roll the ball forward and then backward at a moderate speed.
 4. Rhonda should raise her head to attempt to keep herself in an upright position.

- C. Procedure: See Baby Exercise Book, p. 28

1. Place Rhonda on a wedged cushion 2 inches high or put a rolled towel under her chest so that her arms are stretched out. A hand towel will be just the right size for this. It should just barely extend beyond her chest.
2. Dangle a bell or a music box directly over her head.
3. Leave her in this position for 5 to 10 minute periods during the day as your work around the house.

2. Purpose: To strenghten Rhonda's legs.

Charting Behavior: Rhonda will allow her legs to be straightened and bent alternately 90% of the time.

Procedure: See Baby Exercise Book, pp. 16-17.

1. Place Rhonda on her back.
2. Sit in front of her
3. Support both legs under the knee joint, and toss them gently up and down.
4. Alternately by patting and tossing move one knee up to her chest then the other.

3. Purpose: To encourage reciprocal movements between arms and legs

Charting Behavior: Rhonda will reach with the opposite arm to touch her foot as it is extended towards her 90% of the time.

- Procedure:
1. Place Rhonda on her back.
 2. Hold her under her knees.
 3. Straighten the left leg in the air and bring it towards her head.
 4. Simultaneously guide her right hand to her foot.
 5. Let her release her hold.
 6. Then bring her right leg up to her left hand.
 7. During this activity, tie bells around her wrists and ankles to provide extra stimulation.

4. Purpose: To teach Rhonda to roll from her stomach to her back.
See Baby Exercise Book, pp. 30-31.

Charting Behavior: When Rhonda's head is lifted and shoulder rotated she will turn from her tummy to her side 90% of the time.

- Procedure:
1. Place Rhonda on her tummy.
 2. Place her left hand straight above her head.
 3. Bend her knees under her.
 4. Roll her hips to the left.
 5. Gently lift her chin up and to the right while pushing against her hip to roll her over.
 6. Release your hold on her chin and squeeze a toy near her right ear to encourage her to reach for it.
When she reaches, she will pull herself onto her back.
 7. Repeat 4 times on each side.

SOCIAL ACTIVITIES:

1. Purpose: To increase her awareness of the different parts of her body.

Charting Behavior: Rhonda will touch her tummy or at least one body part 90% of the time when verbally asked to locate it.

- Procedure:
1. During bath time or while playing with her, talk specifically about her body parts.

2. Wash her arm, feet, hands, tummy and legs and say to her "Mommy's (Daddy's) washing Rhonda's leg." Slowly rub the cloth over her limbs.
3. While playing with her, use a soft paint brush and tickle the same spots, encouraging her to "scratch" her arm, tummy, leg, etc. Tell her to "get or touch her _____."

2. Purpose: Rhonda will play "games" with family members and others.

Charting Behavior: Rhonda will initiate pat-a-cake or peek-a-boo 90% of the time when someone verbally cues her to ask if she wants to play that game.

- Procedure:
1. Play pat-a-cake with Rhonda. Before you touch her, ask her, "Rhonda, want to play pat-a-cake?"
 2. Then bring her hands together to play.
 3. Stop part way through and ask "more pat-a-cake?" Prompt her to bring her hands together to indicate she wants more.
 4. Immediately reinforce her gesture by playing pat-a-cake with her.
 5. Continue the same procedure with other games.

3. Purpose: To teach Rhonda to eat lumpy foods.

Charting Behavior: Rhonda will swallow 5 bites of a lumpy food each day.

- Procedure:
1. Place the food on her pacifier and let her first take it from the pacifier.
 2. Then place the same food on the rubber coated spoon.
 3. Place the spoon back on the middle of her tongue and gently but firmly press down.
 4. Close her lips around the spoon and gently hold them closed as you pull the spoon from her mouth.
 5. Keep her lips shut until she swallows.
 6. You may find it easier to prop her against the table as she sits in her infant seat so that you will have both hands free.

LANGUAGE ACTIVITIES:

1. Purpose: To teach Rhonda to communicate with gestures.

Charting Behavior: Rhonda will extend her arms to you to be picked up 90% of the time.

- Procedure:
1. Before picking up Rhonda, ask her "Rhonda, want to come up?" "Give me your arms."
 2. Physically tap her behind her elbows to encourage her to reach out.

3. Say "There are your hands! You want Daddy? Come up!"
4. At first physically guide her to extend her arms.
5. Then simply ask her for her hands, and tap her hands to cue her to give them to you.

B. Charting Behavior: Rhonda will passively allow being guided through gestures before eating or playing.

- Procedure:**
1. Before each bite, physically guide Rhonda to touch her mouth.
 2. Always pair the word eat with the gesture.
 3. Ask her "Rhonda, ready to eat?" Let her smell the food, then say "show me eat" and guide her to make the gesture.
 4. Gradually require her to make the gesture more by herself.
 5. Ask her "Want to eat?" then tap her hand while saying "Rhonda, show me eat."
 6. Follow the same steps for teaching her to tell you when she wants to be changed. Bring her hand to her wet diapers and say "are you wet?" "Yes!" "want dry pants?" then bring her hand to her pants. If she cries to tell you she's wet, bring her hands to her pants but just before say "what's wrong?" then as you help her touch her wet diapers, say "Oh, you're wet!"
 7. Follow the same steps as in 5 to teach her to tell you she wants to play. Use her kicking her legs to represent the play gesture. When she's happy and kicking her legs, go to her and say "Rhonda, you want to play?" Then prompt her to kick and reward her with tickles or give her rattles. Dad can bounce and throw her around. Stop playing and ask her, "more play?" and assist her to kick her legs. Say "Oh, you want to play!" and continue your actions with her.

2. **Purpose:** To teach Rhonda how to make sounds.

Charting Behavior: Rhonda will imitate a /b/ formation 50% of the time when provided with verbal and tactual cues.

- Procedure:**
1. Always talk to Rhonda, letting her feel your face, lips, throat. Particularly encourage her to hold your face as you chew gum so she can feel the up and down motion of your jaws.
 2. Babble ba-ba-ba-ba to her in the tune of a favorite song.
 3. Let her feel your lips.
 4. Babble into her hand.
 5. Place her hands on her own lips as you continue to babble.
 6. Physically hold her lips together as you verbalize the /b/ then open her lips.

7. Let her feel the explosion of air on her cheek as you make the /b/.
8. Reward any attempt on her part to repeat the sound with hugs or bouncing.
9. Imitate any sound Rhonda makes.
10. Babble A's, E's and Oh's to her to provide the verbal stimulation.

COGNITIVE ACTIVITIES:

1. Purpose: To teach Rhonda she can use her own body as a means to an ends.

Charting Behavior: Rhonda will hold on to a toy dangled from elastic for 30".

Procedure:

1. Tie elastic to one of Rhonda's favorite toys.
2. Dangle it in front of her, tapping her hand to encourage her to locate and grasp the toy.
3. Once she grasps the toys, pull up gently but not hard enough to pull it away from her.
4. Lower it again to encourage her to participate in a pulling game. Then pull upward again so she must resist your pull.

2. Purpose: To teach Rhonda to reach for and grasp objects with the thumb side of her hand.

Charting Behavior: Rhonda will grasp objects one inch in diameter with a radial palmar approach 90% of the time.

Procedure:

1. Tap two large jingle bells together, then offer one to each hand near her thumbs.
2. If she doesn't take the bells, press them into her palm against her thumb.
3. Offer her toys with handles or long thick rattles next to her thumbs.
4. Put her socks just over her toes. You may want to have a special pair of socks for this activity, and sew a bell to the wrong side of the sock near the toe. Bring her hand to her foot and guide her to pull off her sock. Once off, she can shake it to produce a sound.

3. Purpose: To teach Rhonda to repeat actions that cause pleasurable things to happen.

Charting Behavior: Rhonda will repeatedly tap a musical toy in imitation of you 90% of the time.

Procedure:

1. Place Rhonda over a rolled towel or sit her propped against your body.
2. Place the roly-poly ball of Happy Apple in front of her.

3. Take her hand and tap the toy. Hold her wrist near the toy to encourage her to repeat the action.
4. Place a stick in her hand and let her strike a drum or xylophone.
5. Play a Jack in the Box or other musical toy. Cease your actions and place Rhonda's hand on the toy then guide her to pat the toy. Repeat your operation of the toy, stop and tap it to encourage her to pat the toy. Tap her hand to cue her to repeat the action.

4. Purpose: To teach Rhonda to track the sounds of toys in order to locate them.

Charting Behavior: Rhonda will reach with her hand or turn her head to the sound of a toy through a 180° 90% of the time.

- Procedure:
1. Using a bell or favorite rattle, begin ringing or shaking it near one side of her head.
 2. When she either reaches for the toy or turns her head to the sound of it, slowly move it to the other side of her head continuing to operate the toy.
 3. If she begins to lose interest before you reach the opposite side, touch the toy to her hand or increase the action of the toy to encourage her to follow it.
 4. Once the toy is on the other side, let Rhonda grasp it.
 5. Repeat this game with several different toys.
 6. Alternate the sides from which you begin.

5. Purpose: To teach Rhonda about the use of different objects.

Charting Behavior: Rhonda will bring a spoon or cup to her mouth 90% of the time.

- Procedure:
1. Before feeding Rhonda, give her the spoon to play with.
 2. Then say "spoon, Rhonda" and place her hand in yours to give you the spoon.
 3. After she takes food from it, return it to her.
 4. Repeat intermittently throughout the feeding process.
 5. Give her a small cup to hold. Say "cup, Rhonda" again placing her hand in yours to give you the cup. Place a sip of a preferred liquid in the cup and give her a sip. A cup with a handle for her to grasp is the best.
 6. Let her manipulate her shoes, pajamas, etc. while dressing. Always give her the name of the object so she will know what it is and what it's used for.

6. Purpose: To teach Rhonda to remember where things are.

Charting Behavior: Rhonda will reach into a container into which she dropped a toy and retrieve the toy 90% of the time.

- Procedure:
1. Guide Rhonda to release a small toy into a wide cup or bowl.
 2. Shake the toy around and place one of her hands on the container.
 3. Prompt her at her wrist to reach into the container to take out the toy.

APPENDIX B

1. Community Resources Survey
2. Community Resources List
3. Rating of Severity of Handicapping Conditions
4. Family Questionnaire

Community Resources Survey

1. What types of services are available through your agency?

- ☐ a. Social
- ☐ b. Medical-Please specify _____
- ☐ c. Psychological
- ☐ d. Educational
- ☐ e. Diagnostic and evaluative-Please specify _____
- ☐ f. Vocational
- ☐ g. Legal
- ☐ h. Financial
- ☐ i. Recreational
- ☐ j. Day care
- ☐ k. Liaison and referral
- ☐ l. Other-Please specify _____

2. What are the criteria for eligibility for your services?

- a. Age _____
- b. Physical requirements _____
- c. Handicapping condition/s _____
- d. Geographic limitations _____
- e. Financial guidelines _____
- f. Other _____

3. Is there a fee for your services? Yes _____ No _____

If yes, how is the fee determined?

- 4. a. Are your services available to the multihandicapped visually impaired and/or their families? Yes _____ No _____
- b. If no, could your services be expanded to include the multihandicapped visually impaired if training workshops or consultation services were made available to your staff? Yes _____ No _____
- 5. Would your agency be interested in workshops or consultation in the area of the multihandicapped visually impaired? Yes _____ No _____

Name of Agency _____

Address _____

Director or Contact Person _____

Phone _____

Comprehensive List of
Community Resources

Compiled by
Home Liaison Office
Model Vision Project
October 1977

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Residential Care

1. Clover Bottom Developmental Center

CBDC is a state facility operated by the Tennessee Department of Mental Health and Mental Retardation; 825 residents, providing residential care, training and educational services, and outpatient services; school programs for children 6 - 21 years of age; diagnostic services available to public. CBDC also operates community-based group homes. Marjorie Nell Cardwell, Supt.

Ms. Hunta Owens, Dir. of Social Services.....741-4392

Mr. Bobby C. White, Supt. for Comm. Services.....741-4574

Stewart's Ferry Pike, Donelson, Tenn. 37214.....741-4388

2. Mur-Ci Home

A residential facility caring for profoundly and severely retarded children from 3 months of age to 18 years of age. In addition to the main facility, Mur-Ci Home operates 3 group homes for ambulatory retarded children. It is a United Way agency and is sponsored by the Murfreesboro Road Civitan Club.

Jeff Shumaker Dir.....361-6446

Toni Crutchfield, Soc. Worker

2120 Murfreesboro Rd., Nashville, Tenn. 37217

3. Home 2, Inc.

Provides two basic services, a short-term respite program and permanent resident facilities for developmentally disabled young adults (18 years and older) falling into the categories of mental retardation, cerebral palsy, epilepsy, and functioning at the mild, moderate, and non-ambulatory level. The respite program (capacity of four) lasts four or five days and is designed to provide parents with relief from the constant care of their handicapped young adults. It also provides the young person the opportunity to experience "independent living" and a program of activities suited to his capabilities. Trained staff live in the 5 houses which operate and provide 24-hour, seven-day-a-week coverage. 1709 19th Ave., South, Nashville, Tenn.....297-8514

4. Residential Services, Inc.

Provides foster care in a family household setting to children ages 0 - 18 years with mental retardation and multiple handicapping conditions. Placement includes multi-children and single child settings. Children attend local school and can receive social services, recreation, and therapy services. Babysitting services are offered to both foster homes and private homes.

Charles E. McLeroy, Jr., Exec. Dir.

Phyllis J. McDonald, Soc. Services

4901 Linbar Dr.

Nashville, Tenn. 37211.....834-3638

Respite CareRespite Care, Clover Bottom Developmental Center

Maximum of 21 days respite care, after which there is a 60-day waiting period to allow more people to use the services. At admission, information is gathered and self-help program is designed to improve skill development. At end of respite, parents or guardians are encouraged to discuss with staff what has been done and effort is made to get them to continue to work with the client. Follow up service and parent training are provided if necessary. Admission hours 8:00 a.m. to noon, Monday - Friday.....741-4344
Call 3-4 weeks in advance.

2. Home 2, Inc.

Provides two basic services, a short-term respite program and permanent resident facilities for developmentally disabled young adults (18 years and older) falling into the categories of mental retardation, cerebral palsy, epilepsy, and functioning at the mild, moderate and non-ambulatory level. The respite program (capacity of four) lasts four or five days and is designed to provide parents with relief from the constant care of their handicapped young adults. It also provides the young person the opportunity to experience "independent living" and a program of activities suited to his capabilities. Trained staff live in the 5 houses which operate and provide 24-hour, seven-day-a-week coverage.
1709 19th Ave. South.....297-8514

1. Metropolitan Public Schools

Special Education Department offers services for exceptional children in these areas: EMR, Specific Learning Disabilities, Hard of Hearing, Home Instruction, Hospital, Partially Sighted and Blind, Physically Handicapped, Multi-handicapped, TMR, and Speech Correction. Transportation is provided.

2601 Bransford Ave., Nashville, Tenn. 37204.....259-5826

2. Clover Bottom Developmental Center

CBDC is a state facility operated by the Tennessee Department of Mental Health and Mental Retardation; 825 residents, providing residential care, training and educational services, and outpatient services; school programs for children 6 - 21 years of age; diagnostic services available to public. CBDC also operates community-based group homes.

Mrs. Hunta Owens, Dir. of Social Services.....741-4392

Stewarts Ferry Pike, Donelson, Tennessee 37214

3. Tennessee School for the Blind

Limited facilities for the multihandicapped but expanding. School furnishes board, lodging, laundry, tuition, books, supplies, and general medical care.

Hours: 8:00 a.m. - 4:30 p.m. M - F

Gary Coker, Principal

115 Stewarts Ferry Pike, Donelson, Tenn. 37214.....741-4431

4. Early Developmental Assistance Program (Toddler Research)

A training program for developmentally delayed children, 15 - 36 months of age. Goal is for realization of each child's full potential.

Director - Paula Goodroe. Box 66, Peabody College

Kennedy Center -- Edgehill and 21st Ave. Nashville, Tn....327-8007

5. Regional Intervention Program (RIP)

Serves families with children up to 5 years who appear to be high risk for institutional care due to severe behavioral disorder, language, or developmental delay; and for whom no other treatment resources exist or are appropriate. Trains the parent to manage their children's behavior and develop skills in order to prevent or delay institutionalization. Parent must attend with child and is trained by "experienced" RIP parents. Parents continue to work in program 6 mos. following treatment. 9:15 - 12:00 p.m. M - F for parent and child.

2400 White Ave. Nashville, Tenn. 37204.....269-5671

6. Child Intervention Program (CIP) (Central State Psychiatric Hospital)

Serves children 5 - 12 yrs. old with serious social and academic problems. May begin serving children with multiple handicaps, providing that behavior disorder is a primary problem. Offers parent training in child behavior, preparation for child entering special classroom setting, and liaison services. May also offer consultation services.

Pam Moss - Rigg, Program Coordinator

2400 White Ave., Nashville, Tenn. 37204.....256-6475

7. Outlook Nashville

After school and summer day care for physically and multiply handicapped children 4 to 14 yrs. of age, providing stimulation of motor skills, communication skills, independent movement skills, cognitive development, and socialization. Other services include parent training, individual and family counseling and information and referral service for cerebral palsied individuals. Also a small infant class for early stimulation.

Hours: 8:30 a.m. - 5:00 p.m. M - F

Carter Steele, Dir.

337 22nd Ave. North, Nashville, Tenn. 37203.....329-9404

Vocational Facilities

1. Goodwill Industries of Middle Tennessee, Inc.

A vocational rehabilitation center for the handicapped, providing vocational evaluation and training and sheltered employment. Provides pre-vocational evaluation over an eight-week period for persons sponsored by the Tennessee Division of vocational Rehabilitation. Also provides work conditioning and adult basic education.

Hours 7:30 a.m. - 4:00 p.m., Monday - Friday

905 9th Ave., North, Nashville, Tenn. 37203.....269-9901

2. Rochelle Center

Referral and activity Center providing referral services. Training and work center for moderately and severely handicapped persons. Providing long-term training and work opportunities for adjustment to outside vocational demands. Director - Harry Gramman.

1020 Southside Court, Nashville, Tn. 37203.....254-0673

3. Hermitage Learning Center

Specialized evaluation and training facility with residential program for males 16 - 18 and day program for males and females 16 and up. Students with behavioral, emotional, mental, or physical disabilities receive comprehensive vocational evaluation and remedial academic, behavioral, and vocational training.

Leon N. Whitmore, Dir.

88 Hermitage Ave., Nashville, Tn. 37210.....741-1606

4. Outlook Nashville, Inc.

Adult activity program provides services designed to maximize independence. Programs range from basic adult education through pre-vocational training for mentally, physically, emotionally, and multiply handicapped.

Hours: 8:30 a.m. - 5:00 p.m.

Carter Steele, Dir.

337 22nd Ave. North, Nashville, Tn. 37203.....329-9404

Day Care Facilities

1. Easter Seal Society for Crippled Children and Adults of Tennessee, Inc.

A day care center offering comprehensive day care services for 28 mentally and physically handicapped children of income-eligible families who live in the Nashville area, ages 3 - 6.

Hours: 8:00 - 4:30 M - F

2001 Woodmont Blvd., Nashville, Tenn. 37215.....292-6639

2. Heads Up Child Development Center, Inc.

Day care program designed to stimulate early development for delayed and non-delayed children of low income families from 15 mos. to 5 yrs. of age. Serves West and North Nashville.

Hours: 8:30 a.m. - 3:30 p.m. M - F 12 mos. a yr.

Eleanor Willis, Dir.

6018 New York Ave., Nashville, Tenn. 37209.....292-4451

3. McNairy Lane Day Care Center for Mentally Retarded Children

Serves mentally and physically handicapped children 3 to 8 yrs. of age. Trains children in self-help skills and counsels parents in aiding their children.

Hours: 7:30 a.m. - 5:00 p.m. M - F

Mrs. Mary Williams, Dir.

2914 McNairy Lane, Nashville, Tenn.....269-4495

4. Duncanwood Day Care Center

Offers a structured educational training service for children age 2 through 11 yrs. who are mentally retarded and/or developmentally delayed. May also accept children who are visually impaired as well. Children must be ambulatory. The schedule corresponds to the Metro Public School schedule with an additional 7 weeks during the summer.

Mrs. Robert Newton, Dir.

4414 Granny White Pike, Nashville, Tenn. 37204.....298-5619

Medical and Diagnostic Resources

1. Bill Wilkerson Hearing and Speech Center

Offers diagnostic and remedial services for all types of communicative disorders. Audiology clinic services for all types of communicative disorders. Audiology clinic services are provided to all age groups, including hearing aid selection, hearing evaluation, speech-reading, and in some instances manual communication programs for children and adults with problems of articulation disorders, cerebral palsy, cleft palate, stuttering, language and learning disorders, etc.

Hours: 8:00 a.m. - 5:00 p.m., Monday - Friday

Earl Harford, Director

119 19th Ave., South, Nashville, Tenn. 37212.....383-2420

2. Vanderbilt University Hospital

Birth Defects Clinic

Offers medical, social work, and physical therapy services to children with hydrocephalus and/or myelomeningocele. Multi-disciplinarian approach. Clinic meets on Monday afternoons

1161 21st Ave. South, Nashville, Tenn.....322-2371

Cerebral Palsy Clinic

Provides services to those children and youth with cerebral palsy. Medical, psychological, physical therapy, and social work services make up the multi-disciplinarian approach.

Clinics meet on Wednesday afternoon.....322-2371

Comprehensive Developmental Evaluation Center

Serving as a referral center to provide thorough diagnostic assessment of children and young adults with developmental problems, placing emphasis on infants and young children. Serves children and young adults from 0 to 21 years of age, who are residents of Middle Tennessee, and who have complex developmental problems for which there are no other diagnostic services available. Fees are set on a sliding scale, but no child is turned away because of lack of ability to pay.

Peggy C. Ferry, M.D., Dir.

21st and Pierce Avenues, Nashville, Tenn. 37232.....322-2709

3. Crippled Children's Service

A state-wide program for the medically indigent from birth to 21 years of age who have handicapping or potentially handicapping conditions.

Provides outpatient care, physicians' and dentists' services, hospitalization and/or convalescent care, all necessary drugs, braces, and other therapeutic aids.

Appointments made by private physicians, Health Dept., families, etc.

Hours: 8:00 a.m. - 4:30 p.m., Monday - Friday

Ben Allen Rd., Nashville, Tenn. 37216.....741-7201

4. Meharry Child Development Clinic

Provides services to infants and children in the pediatric age group (birth to 21 years) who are suspected of being or have been diagnosed as mentally retarded. The full-time professional staff includes pediatricians, psychologists, and social workers. Full use is made of the Pediatric Diagnostic and Training Laboratory in Mental Retardation in the diagnostic investigation of cases. The clinic also utilizes the regular consultation services of a psychiatrist and neurologist. Other necessary medical and paramedical referrals are initiated and followed through by the clinical staff, following evaluation and diagnosis, and assessment of the child's developmental progress. Patients may be referred directly to the Child Development Clinic by an interested person for an initial appointment. There is no fee for service except occasional fees for special laboratory tests.

Hours: 8:00 a.m. - 5:00 p.m., Monday - Friday.

Rodney Hammond, Dir.

1005 18th Ave., North, Nashville, Tenn. 37208.....327-6369

General Resources

1. Davidson Co. Association for Retarded Citizens

(1) Provides information about mental retardation. (2) Developing programs and services for retarded people. (3) Serving as advocates for retarded people in the local community.

Robert Wright

1004 Woodvale Dr., Nashville, Tenn. 37204.....297-2487

2. Tennessee Association for Retarded Citizens

A voluntary statewide organization affiliated with the National Association for Retarded Citizens. Dedicated to improving welfare of all retarded children and adults. Assists parents and friends to form units throughout the state. Promotes research and development of new facilities, legislation, research and education.

Director - Roger Blue.

2121 Belcourt Ave., Nashville, Tenn. 37212.....298-4487

3. Legal Services of Nashville and Middle Tennessee, Inc.

Provides free legal assistance for persons unable to afford private attorneys. Helps with legal problems involving bills, loan companies, garnishments, landlords, child support, welfare eligibility, social security, mistreatment by government agencies, etc. Juvenile courts cases, lawsuits--does not usually bring suits to win money judgments. Provides legal services to organizations of the poor such as neighborhood improvement associations, welfare rights organizations and tenants' organizations to protect their legal rights. Funded by United Way, federal and local government funds, and private contributions.

Hours: 8:30 a.m. - 4:00 p.m.

Ashley Wiltshire, Exec. Dir.

607 Sudekum Bldg., 6th Ave. & Church St. Nashville, Tenn. 244-6317

4. Easter Seal Society for Crippled Children and Adults of Tennessee, Inc.

The Society conducts programs of transportation, equipment loan, purchase of medical appliances and services, public and professional informational services, recreational and resident camping experiences.

2001 Woodmont Blvd., Nashville, Tenn. 37215.....292-6639

5. Services for the Blind

Provides vocational rehabilitation services including as appropriate: counseling and guidance, training, job placement, and varied medical and optical services. Sight conservation designed to prevent blindness and to restore sight through medical care, casework, and education. Home teaching offering help in adjusting to blindness.

1720 West End Bldg., Rm., 301, Nashville, Tenn. 37203

Julia Stewart.....741-2111 or 741-1685

6. American Printing House for the Blind

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Write for catalog of teaching aids and materials from pre-school level to braille aids.
1839 Frankfort Ave.
Louisville, KY. 40206

7. Tennessee Library for the Blind and Physically Handicapped

Provides free library service by mail to individuals with a physical handicap that prevents them from reading a regular print book. Cassette recorders or talking book machines are provided for using tapes and records of books or magazines.

Hours: 8:00 a.m. - 4:30 p.m. M - F

5200 Centennial Blvd., Nashville, Tenn. 37209.....741-3915

8. WPLN Talking Library

Radio Talking Library - Broadcasts can only be received by special receivers obtained through WPLN or Tennessee Library for the Blind. Current reading materials including books, daily newspapers, and current magazines are broadcast along with special learning and practical information. There is a Saturday morning Children's program. Must make application for the receiver.

Broadcast hours: 7:00 a.m. - 6:00 p.m.....259-5081

9. American Foundation for the Blind

Provides information on visual impairment to the public and can provide catalogues of aids and appliances for the blind.

15 West 16th St.

New York, N.Y. 10011

10. Social Security Administration

For supplementary security income. Child must be under the age of 22 and in "school". Funds are based on need. Need to call office and make an appointment.

Hours: 9:00 a.m. - 4:30 p.m. M - F

1600 Hayes St., Nashville, Tenn.....329-3000

11. Family and Children's Services

Provides professional counseling services for personal and family difficulties. Fees based upon a sliding scale.

201 23rd Ave., North, Nashville, Tenn. 37203.....327-0833

Lennard Leighton, Dir. Family Life Services

Referral and Information1. Tennessee - Peabody Referral and Information Center

A comprehensive referral and information resource for persons working with developmentally disabled clients.

Ms. Joyce Whitmer, Dir.

P.O. Box 40, Peabody College

21st Ave. S. & Edgehill, Nashville, Tenn.....327-8240

2. Easter Seal Society for Crippled Children and Adults of Tennessee, Inc.

Assists disabled persons with their families in finding and making effective use of resources which will be helpful in developing necessary and appropriate resources for disabled persons.

2001 Woodmont Blvd., Nashville, Tenn. 37215.....292-6639

Recreational and Social Activities

1. Bowling

Donelson Crescent Bowling Lanes

24 lanes available for bowling. No fee charge for instructional pointers while bowling. Telephone to register for "Learning to Bowl Class" offered for adults; sessions last 5 weeks; class 1-1½ hours. Lessons \$5.00 includes a multi-media presentation.

ALLEY HOURS: Sun. thru Thurs. 9 a.m. - 12 p.m. Fri. & Sat.
24 hours.

117 Donelson Pike 883-3313

Pla-Mor Bowling Lanes

24 lanes and shoe rental available. Free assistance about bowling skills provided for children and adults on Sat. Shoe rental.

ALLEY HOURS: Mon. thru Thurs. 9 a.m. - 12 p.m.; Fri- Sun. 3 p.m. - 5 a.m.

Contact: Mr. Burklin

2906 Creighton Drive 254-5809

Plaza Lanes

24 lanes. Free instructions while bowling at the center. Shoe rental provided.

ALLEY HOURS: Mon. thru Sun. 9 a.m. - 12 p.m.; Summer months- 24 hours.

Contact: Barbara Chalkers & Tom Adams

Donelson Shopping Center 883-8581

Strike'n Spare Bowling Lanes

32 lanes. Fee charged for shoe rental and games. Free instruction for adult bowlers while at the lanes.

ALLEY HOURS: Mon. - Sat. - 9 a.m. - 6 a.m.; Sun. 12 p.m. - 10:30 p.m.

73 White Bridge Road.....352-3726

Tusculum Lanes

24 lanes. No less provided. League and individuals can rent lanes and shoes.

ALLEY HOURS: Mon. - Fri. 9 a.m. - 12:30 p.m.; Sat. & Sun. 2 p.m. - 3 a.m.

5315 Nolensville Rd.....833-2881

2. Dancing

Betty's School of Dance

Private or group classes offered for children and adults. Children's classes: ballet, acrobatics, jazz, baton. Adult classes include ballet and ballroom dancing. Telephone for class fees and appointment.

Donelson Plaza Shopping Center.....883-4927

Jeanne Vaughn Dance Studio

Telephone to register for adult ballet, children's session for tap, modern jazz, and ballet. Fee charged for class.

Hours: 10 a.m. - 5 p.m. Mon. - Fri.

2948½ Nolensville Rd.....832-4787

3. Roller Skating

Charlotte Skating Center

Skating at center for children and adults. Rental fee for skates admission - \$1.25.

Hours: 7 - 10 p.m. Mon. - Thurs.; 7 - 10 p.m., 10 - 1 a.m., Fri.
7 - 10 p.m. Sat.

401 American Road.....356-9570

Donelson Roller Rink

Gralyn Drive

Hours: Thurs., Fri., Sat. - 7 - 10 p.m.; Sat. 12:30 - 2:30 p.m.;
Sun. 2:30 - 5:00 p.m.

Highland Skateland

3720 Nolensville Rd.....832-4383

Hours: Mon., Tues., Thurs. - 7:30 p.m.; Fri. 3:30 - 6:00 p.m.;
7 - 10 p.m.; 10 - 1 a.m.; Sat. 12 - 4 p.m.; 7 - 10 p.m.; 10 - 1
a.m.; Sun. 2 - 5 p.m.; 7 - 11 p.m. (black nite)

Nashville Skating Center

294 Luna Drive.....834-1714

Hours: Same as Charlotte Skating Center

4. Swimming

American National Red Cross

Trained volunteers conduct an Adapted Aquatics class at a community pool. No age limit, no fee charged. Physician's consent is required. Request and complete application form.

Contact: Carol Ford.....327-1931

321 22nd North Office hours: M - F 8 - 4:45 p.m.

5. Camping

Easter Seals Society for Crippled Children and Adults of Tenn., Inc.

Summer camping at the Easter Seal Camp for Crippled Children on Old Hickory Lake in Mt. Juliet, Tenn. Persons 6 years and older attend camp during five 11-day sessions held in June and July. Camp activities include: archery, boating, nature experiences, arts and crafts, swimming, table games, ball games and picnics. Complete camp application form. No fee charged for camp.

Contact: Gene Nabi, Exec. Director

2001 Woodmont Blvd.....298-3386

Hours: 8:30 - 4:30 p.m. M - F

6. Variety of activities

Metropolitan Recreation Dept. - Metropolitan Board of Parks and Recreation

Telephone or write to register for the free Metro Parks Handicapped Program. 6 years and older meet at the various Metro Parks Centers throughout the year to participate in the planned activities: Swimming, arts and crafts, bowling, day camp, fishing etc. Transportation provided for persons residing within the van routes.

Contact: Mrs. Cathy Rader, Dir. of Recreation for Handicapped Children and Adults.

Centennial Park.....259-6399

7. Theatre

Children's Theatre

724 2nd Ave. S.....254-9103 or 254-6020

8. Social Activities

Teen Town Program for mentally retarded young people, meets semi-monthly
at the Rochelle Center. Ages 11 up.

Contact: Mrs. Tribke

1020 Southside Court.....833-5161

New Horizons Adult Activity Center for the Handicapped, Inc.

Offers 5-day-per-week activities with persons 18 - 35 years of age.

Program includes learning of household tasks and introduction to
work. Capacity of 21

Contact: Wanda Burkett, Dir.

1943 Dabbs Ave., Nashville, Tenn. 37217.....255-0506

Outlook Nashville TNT Clubs

Operates a dozen clubs for the handicapped in Nashville area staffed
by volunteers. Each club has its own age eligibility requirements,
starting at 12 years. A variety of recreational and social activities
are planned by the members

Central Office - 337 22nd Ave. North, Nashville, Tenn. 37203

Carter Steele, Dir.....329-9404

Cheatham County1. Cave Springs Home and School

Serves mentally or physically handicapped individuals 17 to 30 yrs. of age who are ambulatory. Provides self-help training, work activity, individual tutoring, and recreation. No geographical restrictions.

P.O. Box 158, Highway 70

Pegram, Tenn. 37143.....352-1569

2. Cheatham County Association for Retarded Citizens

(1) Provides information about mental retardation. (2) Developing programs and services for retarded people. (3) Serving as advocates for retarded people in the local community.

Mrs. Joyce Anderson

Riverview Dr., Pegram, Tenn. 37143.....352-2584

3. Cheatham County Assn. of Retarded Citizens Group Home

Riverview Dr.

Pegram, Tenn. 37143.....352-2584 or 746-4697

4. Cheatham County Board of Education

102 Elizabeth St.

Ashland City, Tenn. 37015.....792-5729 or 244-4018 (Nashville)

Sumner County1. Handicapped Adult Training Services

Provides training to physically and mentally handicapped adults (18 and over) in areas of self-help, socialization, academics, and community living.

Hours: 8:30 - 4:30 (office) 9:00 - 2:00 (client)

Rt. #3, Long Hollow Rd.

Gallatin, Tenn. 37066.....451-0974

2. Sumner County Association for Retarded Citizens

720 Mike St.

Gallatin, Tenn. 37066

Mr. Terry Allen.....255-8667

3. Sumner County Board of Education

117 East Winchester St.

Gallatin, Tenn. 37066.....452-4080 or 452-1632 (Pupil Services)

4. Tennessee Vocational Training Center

Evaluates and provides work adjustment training to persons 16 and over who are vocationally handicapped due to mental or physical handicapping conditions. The evaluation consists of numerous tests and paid work activity in a sheltered workshop.

Hours: 8:00 - 4:30 M - F

Rt. #2, Cairo Rd.

Gallatin, Tenn. 37066.....452-5819

Peabody Student Council for Exceptional
Children Babysitting Service

This service has a set fee of \$1.50 per hour with 25¢ going to SCEC.

NAME

GENERAL INFORMATION

1. John Dalton Has been a Sunshine Saturday Counselor during 1976-1977, as well as Fall 1977. Has had a variety of babysitting experiences with infants through 15-year olds. Is willing to work with any age and any type of exceptionality. During the fall semester he can work weekends, days and nights only. Spring semester is not definite as of yet. Age 21. Can provide his own transportation.
West Hall, room 203.....327-8571 (after 8:00 p.m.)
2. Beth Davis Has worked 5 years with children aged infants to 12 years. Teen teacher aide one year in school for retarded. Worked with ages 8-12. Practicum experience one semester, ages 12-15 BD. Two younger sisters: willing to work with children aged infant to 12 years; prefer blind and/or deaf. Available Mon. 9:30 a.m. - 2:30 p.m.; 6:00 - 12:00 p.m., Tues. 7 - 12 p.m. Fri. morning - 2:30 p.m.; Sat. all day. Age 20. Cannot provide own transportation. Gillette Hall, Room 605
.....327-8601
3. Cathy Furlong Has worked with EMR, learning disabled, behavior disordered, and epileptic children. Babysitting experience since high school. Willing to work with all ages; prefers no lower than EMR. Available Fri. night beginning at 5 p.m. through Sun. night. ("overnight weekends") Age 21. Can provide own transportation. North Hall, Room 423.....327-8767
4. Cindy George Sitting for "normal" children and for a boy that has myelomeningocele - also tutoring him. School practicum and day camp volunteer. Willing to care for children under 16 and with any form of exceptionality. Available for most evenings and possible "over night weekends"; also Thurs. and Fri. afternoons. Age 20. Can provide own transportation, most of the time. Apt. C-4, 6565 Premier Dr. (Off of Charlotte).
.....356-3358
5. Carol Gusweiler Volunteer work at a day camp for the mentally and physically handicapped children and adults; worked at a resident home for MR and several practicums with various children (LD, BD, MR). Will care for any age level; prefers any exceptional except physically handicapped. Would have to call for time available. Age 20. Cannot provide own transportation.
North Hall, Room 402.....327-8705

6. Wendy Johnson ¹⁵⁴
Three years volunteer work in a day care center. Willing to care for 8 - 16 year olds. Prefers MR. Available Tues. after 12:30; Thurs. after 3:00; Fri. after 3:30 until early evening; weekend days - Sundays. Age 19. Can provide own transportation. Gillette Hall, room 404.
.....327-8573
7. Andrew Kelsay
Worked as a volunteer with profound children and two summers at a summer camp for retarded children. Prefers 6 - 16 year olds and MR (any aspect). Available Mon. 10:00 a.m. - 12:00 p.m.; Tues. 7:00 - 11:00 p.m.; Thurs. 7:00 - 11:00 p.m. Age 20. Can provide own transportation. West Hall, Room 300.
.....327-8867
8. Leslie Kunkel
Has worked with an EMR girl; LD children, and gifted child. Willing to care for any age and any exceptionality except trainable mentally retarded. Available "over-night weekends"; after 4 p.m. weekdays, and "plain" weekends. Age 20. Cannot provide own transportation. Gillette Hall, Room 607.....327-8634
9. Sally Main
Has worked at a nursing home with older patients, has a blind aunt. Willing to work with infants to eighth graders. Prefers to work with blind & mentally retarded. Available evenings; weekends; "over-night" weekends. Age 18. Cannot Provide own transportation. Confederate Room 206.
.....327-8657
10. Linda Messamore
Has brother who is classified as severely to profoundly mentally retarded. Has done volunteer work with retarded children and adults in private institutions, NARC sponsored programs, and public school programs (all levels of ability; some physically as well as mentally impaired). Experience with hyperactive children; also worked with autistic children. No special preference as to age; prefers MR, hyperactive, and autistic children. Available for "overnight" weekends; also Mon. 9 a.m. - 9 p.m.; Tues. 6 - 10 p.m.; Wed. 9 - 5 p.m.; 6 - 10 p.m.; Thurs. 5:30 - 10 p.m.; Fri. 9 - 6 p.m.; 8 - 10 p.m.; Sun. 12 - 10 p.m. Age 18.....327-8636
11. Janelle McKenney
Experience working with LD, BD, and MR children. Willing to care for any age level, no preference as to exceptionality. Available Tues. and Wed. night, 6 p.m. on. Age 24. 1506 18th Ave. S.....297-8451
12. Wendy Pawlak
Has worked with children of infancy to 14 years old at a day care center in Florida. Tutored a BD child for 5 years. Willing to care for any type of exceptionality. Available Mon. - Thurs. after 5 p.m. Gillette Room 526. Age 20.....327-8586

13. Karen Seefeld Babysat many years for neighbors and nephew. Was a girl scout counselor for 5 weeks last summer. Willing to care for any age, any exceptionality. Available Tues. and Thurs. after 2 p.m.; most any night during the week; "over-night weekends". Age 18. Cannot provide own transportation. Confederate Hall, Room 205.
.....327-8647
14. Missy Walton Has been a Sunshine Saturday Counselor for 2 years; a camp counselor; many years babysitting for her brothers and sisters as well as for neighbors. Willing to care for any age level, preferably blind or deaf. Call for hours available. Age 20. Cannot provide own transportation. North Hall, Room 413.....327-8738
15. Joanie Waldecker Has been a clinician at the Children's Developmental Clinic at PGCC in Maryland for three semesters and this past summer. Worked at a day care center ages infant to eight years; babysitting since age 12 for neighbors and 3 nephews and 1 niece; experience with hyperactive, deaf, autistic, ED, LD, MR slightly motor impaired, and emotionally disturbed; Sunshine Saturday group leader last year and an aide this year. No specific preference as to ages or exceptionality, though very interested in deaf children. Call for hours available. Age 21. Can usually provide own transportation. North Hall, Room 508.....327-8804
16. Kerry Wolston Many experiences babysitting; has worked with MR, LD children. Willing to care for any age level and any exceptionality. Is available evenings and for "overnight weekends". Age 19. Cannot provide own transportation. North Hall, Room 212.....327-8774

This list may change every year as they are all students. For an updated list next fall, contact the Peabody Referral and Information Center.....327-8240.

BD-Behavior Disordered
ED-Emotionally Disturbed
LD-Learning Disabilities
MR-Mentally Retarded
EMR-Educable Mentally Retarded

Rating of Severity of Handicapping Conditions

Code: 1-Mild, 75-99% functional
 2-Moderate, 50-74% functional
 3-Severe, 25-49% functional
 4-Profound, 0-24% functional

Code # of child	CA	Mental	Vision	Physical	Social	Emotional
01	13	3	3	3	2	2
02	13	2	4	4	2	3
03	20	4	4	2	4	4
04	18	4	4	2	4	4
05	17	4	4	4	2	2
06	6	4	2	3	2	2
07	6	2	4	4	2	3
08	12	3	4	2	2	4
09	16	4	2	2	4	3
10	16	4	2	2	4	3
11	4	1	1	1	1	1
12	14	3	4	2	3	4
13	4	3	4	3	2	4
14	18	4	4	4	4	4
15	3	4	4	4	2	2
16	8 mos.	2	4	4	2	2
17	8 mos.	2	4	4	2	2

Code # of child	CA	Mental	Vision	Physical	Social	Emotional
18	2½	4	3	4	3	4
19	6	4	4	4	2	2
20	9	3	4	3	3	3
21	11	3	4	2	2	2
22	11	4	4	2	2	2
23	18	4	2	3	4	3
24	3½	3	3	3	2	2
25	13	3	4	1	2	2
26	15	4	4	1	3	3
27	14 mos.	3	3	3	1	1
28	3½	3	4	3	1	1
29	8	3	2	1	2	2

Carefully read the following questions or statements and check the appropriate answers for your family in the boxes in the right hand column.

1. Are there educational, medical, or support services you are not currently receiving that you need in order to further help your child?
2. Are you now or would you like to be more involved in planning your child's education?
3. We have listed things that parents are frequently concerned about. Would you like information about any of the following?

Further information about your child's medical condition.

Medication

Surgery

Mechanical Aides (e.g., glasses, wheelchairs)

Orthopedic Devices (e.g., leg braces)

Physical Therapy Services

Counseling Services

Rights of Handicapped Children

Babysitting Services

Other _____

4. Does one or more of the following problem areas make it difficult for you to be as involved with your child's educational program as you would like to be?

Medical Problems

Financial Problems

Legal Problems

Family Problems

Marriage Problems

Transportation Problems

"Bad" Feeling Problems

Limited Time

Other (specify) _____

5. Does your family have a need for more recreational activities for your handicapped child? (i.e., picnics, outdoor play)

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6. Would it be helpful to your family if your child could be placed in a program for a short time so the family could do things you may not now be able to?

7. Do you know respite care programs that are available?

8. Does family need information or training in any of the following areas, please check those that apply to your family:

Common Problems of the Eye

Care of the Eye

How Children Learn

Selfhelp Skills, i.e., feeding

Orientation and Mobility; i.e., movement skills, such as sitting, crawling, walking

Managing Your Child's Behavior

Community Interaction, i.e., trips to the grocery store

How to Deal with Agencies

What Resources are Available in the Community to Serve my Child

How do Deal with Schools

Other _____

9. Would you be interested in meeting with other parents to discuss common problems, common solutions, and plan for better services for handicapped persons?
10. Please check the services you and/or your child are currently receiving or will be receiving in the fall.

Diagnostic

Educational Services

Mobility Training

Public Transportation to Educational Facility

Orthopedic Services

Speech Therapy

Physical Therapy

Social Work Services

Vocational Counseling

Parent Training Activities

Legal Counseling

Financial Counseling(e.g., Family Budget Planning

Training in the Use of Prosthetic Devices and
Mechanical Aides (e.g., wheelchiar, leg braces, hearing
aides)

Parent Group Meeting

Home Liaison Teacher Services

11. Please note any needs not mentioned in the above questionnaire which
your family has.

APPENDIX C

1. Job Specifications - Clinical Teacher
2. Competencies for MVP Staff Positions
3. Contract
4. Monthly Activity for Model Vision Project
5. Monthly Activity Memorandum

JOB SPECIFICATIONS
CLINICAL TEACHER - HALFTIME POSITION

I. Direct Services to Children and Professionals

Serve as consultant to teachers and other professionals who work directly with multiply handicapped visually impaired children. Provide technical assistance and hands-on demonstration with children in areas requiring specialized knowledge such as:

1. Vision training.
2. Classroom organization.
3. Handling behavior problems.
4. Handling health problems.
5. Prosthetic strategies.
6. Teaching strategies to facilitate learning.
7. Development or adaptation of materials.
8. Selection of materials and methods based on child's strengths and needs.
9. Curriculum development.

II. Indirect Services

- A. Arrange and coordinate in-service sessions and workshops for agencies or programs serving the target population.
- B. Prepare and deliver in-service sessions and workshops.
- C. Develop information packets on training and materials for dissemination to agencies, programs, or individual professionals serving the target population.
- D. Serve as consultant to school system re:
 1. Appropriate educational placement and services for multiply handicapped visually impaired children.
 2. Development of Individualized Educational Prescriptions.

COMPETENCIES FOR MVP STAFF POSITIONS

Clinical Teacher has:

1. Ability to demonstrate skill in assessing, targeting goals, and intervening to influence the development and education of SH, MH, VI children and to evaluate traditional special education services in the local public schools.
2. Ability to identify and quantify auxiliary service needs of SH, MH, and VI children.
3. Ability to isolate and correct counter or non-productive elements affecting service delivery
4. Ability to improvise feedback mechanisms with interested others affecting service delivery.
5. To generate service delivery alternatives within the context of dynamic school community relationships.
6. Ability to demonstrate familiarity with concepts and vocabulary of participating professional disciplines.
7. Ability to respond with sensitivity to work ethics and protocols of various auxiliary disciplines.
8. Knowledge of charting procedures, including use of 6-cycle graphing techniques
9. Knowledge of an appropriate selection and use of commercial instructional materials
10. Ability to construct and use teacher-made materials constructively
11. " implement psycho-educational prescription
12. " organize an individually structured orientation program for the
13. " pupil should the situation warrant such
14. " train and work constructively with paraprofessionals
15. " work constructively with support personnel
16. Ability to identify significant auditory stimuli
17. Knowledge of basic optical magnifying principles on focal distance and peripheral distortions
18. Ability to task analyze behaviors
19. Knowledge of class-manager role of teacher
20. Ability to utilize the following curriculum units
 - a. motor development
 - b. sensory-perceptual development
 - c. daily living skills development
 - d. communication skills development
 1. verbal communication
 2. non-verbal communication
 - e. recreation and leisure-time skill development

I. Home-Liaison Service Specialist has:

1. Ability to demonstrate knowledge of various parent training delivery systems.
2. Ability to identify and assess child-family behavior patterns.
3. Ability to demonstrate knowledge of parent training components and strategies.
4. Ability to conduct assessment of child-family patterns.
5. Ability to develop, implement, and evaluate intervention programs employing parents as primary behavior change agents.
6. Ability to identify the available resources and to develop techniques and strategies for providing supplemental service needs to severely handicapped children.
7. Ability to implement a plan to provide supplemental services for severely handicapped children with visual impairment.
8. Ability to prioritize direct service activities.
9. Ability to counsel with parents and interested others
10. Ability to assist in evaluation of adequacy of home environment
11. Ability to model child management and child training programs in the home
12. Ability to conduct informal screening/assessment of children in all developmental areas
13. Knowledge of technical aspects of blindness

II. Orientation and Mobility Services Specialist has:

1. Ability to identify the self-help and home living skills.
2. Ability to develop skill in designing and implementing instructional programs to facilitate self-help, home living, and orientation and mobility skills.
3. Ability to demonstrate skill in targeting, designing, implementing, and evaluating a program aimed at skill acquisition in the areas of home, self-help, and orientation and mobility skills.
4. Knowledge of implications of environment, learning and practice in motor learning
5. Knowledge of development of body schema
6. Ability to prepare sequential orientation programs
7. Ability to prepare sequential independent travel programs
8. Ability to utilize residual vision in individual program development
9. Ability to recognize common orientation and semi-independent travel problems
10. Knowledge of techniques used in training of paraprofessionals
11. Experience in utilizing the following curriculum units
 - a. major development training
 - b. sensory-perceptual training
 - c. daily living skills training
12. Knowledge of functioning of multi-disciplinary team from point of view other than that of a teacher

III. Teacher Competencies:

1. To identify and recognize the various functional tools and apparatus (e.g., manual communication, braille, self-help feeding devices, etc) and to utilize the special functional tools and apparatus in providing for the special needs of severely handicapped child in visual impairment.
2. To identify developments in current curriculum and special instructional materials for use with severely handicapped children with visual impairments. To develop, implement, and evaluate intervention programs for modifying motor language, social, and/or cognitive behaviors.
3. The teacher must be able to
 - a. present clear auditory and visual stimuli
 - b. assure child is attending to appropriate stimuli before instruction is given
 - c. use appropriate praise
 - d. use descriptive praise
 - e. have peers model correct response following individual task error
 - f. collect academic rate data
 - g. determine probable source of errors and problems in the instructional program
 - h. modify the program to correct the problem
 - i. use non-social reinforcers appropriately by following a specified contingency procedure and schedule
 - j. devise and employ a criterion-referenced test to evaluate progress/mastery. It must contain the following elements:
 - k. use the following types of materials appropriately to implement an instructional program:
 - teacher made materials
 - commercial materials
 - adapted materials
 - programmed materials
 - l. implementing psycho-education prescription
 - m. record observations
 - n. select and use of appropriate instruction materials
 - o. demonstrate parent training techniques
 - p. Prioritize training goals
 - q. organizing conducive environment
4. have knowledge of normal and exceptional child development knowledge of etiology of disabilities represented by multi-handicapped population
5. organizing conducive learning environment demonstrate training techniques for school aides implement team educational recommendations
6. implementing prescriptive programs experience with the following curriculum units

IV. Diagnostic Services Specialists Competencies:

1. Organize interdisciplinary team members for the assessment of a severely handicapped child.
2. Schedule a comprehensive assessment of a severely handicapped child over a 3 to 5 day period.
3. Arrange testing rooms and materials prior to assessment process.
4. Select a screening instrument that will yield data critical to further adaptive, linguistic, motoric and socialization assessment.
5. Screen auditory, visual and neurological processes for purposes of determining the necessity of a more extensive evaluation.
6. Based on the screening data, identify behavioral management techniques that serve to increase desired behaviors and decrease undesirable behaviors
7. Based on the screening data, select formal cognitive assessment instruments, subtests, and informal developmental tasks appropriate for the developmental level and handicapping condition(s) of the child.
8. Administer, adapt, and score formal cognitive assessment procedures to severely handicapped children also exhibiting visual, auditory, or neurological or any combination of these impairments.
9. Identify strengths and weaknesses in the cognitive progression of specific severely handicapped children based on assessment of cognitive-adaptive abilities.
10. Identify major stages in the acquiring of normal cognitive processes.
11. Identify the effects auditory, visual, and neurological impairments have on normal cognitive development.
12. Select and administer prevocational activities appropriate for the child's motoric and cognitive functioning levels.
13. Based on the screening data, select formal fine motor assessment instruments, subtests, and informal developmental tasks appropriate for the developmental level and handicapping condition(s) of the child.
14. Administer, adapt and score formal motor assessment procedures to severely handicapped children also exhibiting visual, auditory or neurological or any combination of these impairments.
15. Identify strengths and weaknesses in the motoric progression of specific severely handicapped children based on assessment of motoric abilities
16. Identify major stages in the acquisition of normal fine and gross motor development.
17. Identify the major reflexes and their relation to normal and abnormal motor development.
18. Identify the effects visual and neurological impairments have on the progression of normal motor development.
19. Identify the effects abnormal motor patterns have upon cognitive and self-care skills
20. Based on the screening data, select formal language instruments subtests, and informal developmental tasks appropriate for the developmental level and handicapping conditions of the child.

Diagnostic cont. (2)

21. Administer, adapt, and score formal communication assessment instruments to severely handicapped children also exhibiting auditory, visual, neurological, or any combination of these impairments.
22. Identify strengths and weaknesses in the linguistic communicative progression of specific severely handicapped children based on assessment of linguistic communicative abilities.
23. Identify major prerequisite skills essential for symbolic communication.
24. Identify major stages in the acquisition of normal language skills both verbal and nonverbal in nature.
25. Identify the effects visual, auditory, neurological, and intellectual impairments have on the progression of normal language development.
26. Based on the screening data, select formal social, self-care instruments, subtests, and informal developmental tasks appropriate for the developmental level and handicapping condition(s) of the child.
27. Administer, adapt, and score formal social, self-care instruments to severely handicapped children also exhibiting visual, auditory, neurological, or any combination of these impairments.
28. Identify strengths and weaknesses in the socialization progression of specific severely handicapped children based on the assessment of social, self-care abilities.
29. Identify major stages in the acquisition of sequential social, self-care abilities.
30. Identify the effects auditory visual, neurological and intellectual impairments have on the normal progression of socialization skills.
31. Orally communicate to parents, teachers and community liaison agencies, results of the assessment process.
32. Report in a written form an interpretation of the child's performance in cognitive-adaptive, language, motor, and socialization areas.
33. Devise a prescriptive program based on results obtained from cognitive-adaptive, motoric, language and socialization assessments.
34. Suggest teacher and commercially made materials and activities that will facilitate the next sequential skill in the hierarchy of cognitive-adaptive, motor, language and socialization skills.
35. Ability to identify the special techniques and strategies for assessing sensory systems and the cognitive, linguistic, social, and motor processes of handicapped children with visual impairment.
36. Ability to assess the sensory systems and the cognitive, linguistic, social, and motor processes of the severely handicapped.
37. Ability to assess functional behaviors in levels in each of four developmental areas for severely handicapped children with visual impairments.
38. Ability to identify theories of child development by demonstrating knowledge of:
 1. major conceptualizations of cognitive development
 2. social behaviors in young children
 3. linguistic development theories related to young children
 4. motor developmental stages in young children
39. Ability to identify developmental levels of severely handicapped children with visual impairments in motor, social, language, and cognitive skills.

- a. motor development
- b. sensory development
- c. cognitive development
- d. socialization/affection development
- e. daily living skills development
- f. pre-academic education
- g. pre-vocational education
- h. skills for handling severely physically disabled children

Organize and conduct volunteer orientation programs

- 7. Knowledge of etiology of handicapping conditions
- 8. Knowledge of handling special health problems
- 9. Knowledge of roles of auxilliary personnel
 - a. physical therapist
 - b. occupational therapist
 - c. mobility instruction
 - d. speech therapist
- 10. Knowledge of exceptional child development
- 11. Knowledge of normal child development
- 12. Knowledge of formal school faculty protocol

Vocational Services Specialist has:

1. Ability to devise a task analysis which reflects the following attributes:
 - all components stated in terms of observable behaviors
 - prerequisites specific to terminal task
 - prerequisites referenced to initial task (s) in the sequence
 - prerequisites circumvented to avoid overloading where possible
 - analysis complete, without developmental or logical gaps and with tasks clearly subdivided into manageable steps
2. Knowledge of physical handling techniques specific to blind children
3. Knowledge of exceptional child development with specific emphasis on blind-child development
4. Ability to analyze school/residence environments to identify physical and temporal attributes
5. Knowledge of conduction of organized child-care worker information & training programs
6. Ability to develop informal social school/community experience programs
 - a. pre-vocational education
 - b. cognitive skills
 - c. socialization/affective development
7. Ability to identify strategies for functioning responses to auditory and residual visual stimuli

CONTRACT

Model Vision Extension

Workscope: Gray McKenzie
Project Manager (acting)

Dates: May 10 - August 30

Report to: Rebecca DuBose until further notified

1.0 General Information1.1 Planned Activities for May 15-31

Following the attached guideline, fill in the May plan sheet and give to DuBose, one copy to Harley, one for your records.

Due Date: May 16

1.2 Completed Activities May 15-31

Following the attached guideline, fill in accomplishments for May dates and give to DuBose, Harley and one for your records.

Due Date: May 31

1.3 Planned Activities June 1-30, August 1-31

Following the model for May, prepare June and August planning sheets.

Due Date: June 1, August 1

1.4 Completed Activities June 1-30, August 1-31

Following the model for May, prepare June and August accomplishment sheets.

Due Dates: June 30, August 30

1.5 Appointments to review progress and note concerns

May 17	1:00 - 1:30
May 31	1:00 - 1:30
June 16	1:00 - 1:30
X June 22	~~1:00 - 1:30~~
July 12	1:00 - 1:30
August 2	1:00 - 1:30
August 30	1:00 - 1:30

2.0 Workscope Expectations

2.1.0 Work related to Home Liaison Counselor

- 2.1.1 Completion of all objectives assigned to Home Liaison person in MVP Grant or as negotiated in subsequent revisions.

Due Date: June 30

- 2.1.2 Write-up of fourth Quarterly report of all objectives/activities accomplished between April 1 - June 30.

Due Date: June 20

- 2.1.3 Write-up of Annual Report of all work accomplished by Home Liaison Counselor during the third year.

Due Date: Draft: August 9
Final: August 23

- 2.1.4 Write-up of three year Final Report of all work accomplished by Home Liaison Counselor during the three year period.

Due Date: August 28

2.2.0 Work Related to MVP Extension Counselor for Home Liaison

- 2.2.1 Parent Involvement Section of Dissemination Materials

Due Date: Draft: July 10

Due Date: Final: July 28

- 2.2.2 Implications of Blindness

Due Date: Draft: July 10

Due Date: Final: July 28

- 2.2.3 Self-Help/Self Care

Due Date: Draft: July 10

Due Date: Final: July 28

- 2.2.4 Methods of Teaching and Classroom Management for MH

Due Date: Draft: July 10

Due Date: Final: July 28

- 2.3.0 Work related to Acting Project Manager Assignment
- 2.3.1 Provide a dated log of all materials turned in to Project Manager from May 15 - August 30.
- 2.3.2 Provide a file containing one copy of all written materials noted in log.
- 2.3.3 Develop a file of all materials to be submitted with final report.
- 2.3.4 Develop a file of all materials to be used in Outreach Project plan and,
- 2.3.5 Conduct a 30-minute staff meeting each week to go over staff developments and/or concerns.
- 2.3.6 Prepare and distribute minutes of all staff meetings.
- 2.3.7 Plan and conduct the final meeting of the MVP Advisory Committee.
- 2.3.8 Hire secretary for MVP and MVP extension. Prepare a report to DuBose on the new employee. Oversee her orientation to both Peabody and the MVP activities.
- 2.3.9 Edit all material for fourth quarterly report.
- Due Date: Draft: June 22
- Due Date: Final: June 29
- 2.3.10 Edit all material for Annual Report.
- Due Date: Draft: August 9
- Due Date: Final: August 23
- 2.3.11 Edit all material for Final three-year report
- Due Date: Draft: August 23
- Due Date: Final: August 28
- 2.3.12 Prepare contracts for all MVP Extension employees
- Due Date: Drafts: August 25
- Due Date: Final: August 31
- 2.3.14 Edit all material to be submitted to ERIC

Due Date: Draft: August 10

Due Date: Final: August 31

I have read the above contract and accept the conditions described therein.
If for some reason, a portion of this contract can not be completed on time,
I will notify DuBose and Harley in writing prior to the deadline.

Gray McKenzie
Gray McKenzie
Home Liaison Counselor
Project Manager (Acting)

Rebecca F. DuBose
Rebecca F. DuBose
Coordinator

Randall Harley
Randall Harley
Principal Investigator

MONTHLY ACTIVITY FOR MODEL VISION PROJECT

MONTH August

DATE August 1, 1978

TEACHER Gray McKenzie

SPECIFIC ACTIVITY	COMPLETION DATE	PRODUCT
Planning meeting with Orange Grove - Aug. 2 and 3.	August 8	1. List of identified trainees Tentative schedule for training Rough draft of newspaper article Rough outline of master plan
Learn administration of Cattell and vision screening.	August 4	2. Competence required to administer Administration of both to O.G. Clients
Ordering of materials, etc. for project	August 21	3. MVP library complete Materials for testing available.
Compile complete pretest divided into areas. Orientation and in-service with O.G. staff TV and newspaper interview Meeting with Earl Davis Meeting with Chattanooga City and Hamilton County administrators	August 22 August 23, 24, 25	4. Pretest ready for use at O.G. 5. Public information program initiated. Coordination and cooperation with other agencies initiated.
Coordinate dissemination material disposition with Larry Leslie. Edit all new dissemination material for consistency in terms. Complete draft of Final Report.	Ongoing Ongoing Hopefully by August 22 - I am going to give this everything I've got, and it <u>will</u> be done as soon as I possibly can. Within 1 week of draft completion.	6. Completed booklets for dissemination and training. 7. Drafts ready for Project MORE. 8. Draft ready for review by Drs. Harley and DuBose.
202 Corrections or changes made in Final Report.		203 174 9. Final report printed and mailed.

GEORGE PEABODY COLLEGE *for* TEACHERS

NASHVILLE, TENNESSEE 37203

M E M O R A N D U M

August 1, 1978

TO: Drs. DuBose and Harley
FROM: Gray
RE: Activities for the month of July

1. Completed editing of 4th quarterly report, had it printed, and mailed 5 copies to Washington on July 8, 1978.
2. Compiled parent packet of information about insurance programs for the retarded, legal issues, and Mike's recreation program and wrote a final letter to be included which pointed out the usefulness of the Liaison and Referral Office and the Office of Developmental Disabilities. Mailed July 12, 1978.
3. Conferred with Liz about immediate needs for Outreach Project in preparation for meeting with Orange Grove personnel. Prepared agenda for meeting.
4. Met with Liz, Bob, Dr. DuBose, and Dr. Harley prior to Orange Grove meeting to discuss topics on agenda and the status of our preparation and to brief Dr. Harley and Bob about Outreach plans and immediate needs.
5. Prepared Community Survey Form, Community Resources List, Parent Needs Assessment Form (already developed), and brochure, etc. to be given to Orange Grove as examples for their use.
6. Traded Instructional Materials packet to Liz in exchange for MVP brochure on positive aspects of the population. The copy is ready, but pictures and 3 brief case summaries are needed.
7. Met with MVP staff and Orange Grove personnel for preliminary planning July 14, 1978.
8. Collated all quarterly report and annual report materials from all three years according to goal and topic.
9. Compiled list of all questionable or missing information referred to in reports and distributed memo addressed to this problem on July 25, 1978.
10. Re-edited Harris-Hillman dissemination packet for consistency of descriptor of target population and organization. Completed on July 20, 1978.
11. Met with Bob and Liz regarding planning needs for Aug. 2, 3, 4 trip to Orange Grove. We went through the grant goal by goal to determine the activities we need to discuss with them and the materials and forms we need to prepare. July 25, 1978.
12. Met with Dr. Harley, Barbara McLean, and Larry Leslie regarding Project More's current resources for editing, typing, designing format, and printing of materials. I prepared a list of all materials and what they needed. Ms. McLean indicated that the money we have previously paid should cover our needs.

13. Edited Beth's assessment packet for clarity and consistency of descriptor of target population. Completed on July 31, 1978.
14. Prepared tables of contents and credit pages for several dissemination packets in preparation for Project More.
15. Conferred with Liz about existing pre-tests and which questions we can use. We have formulated a plan for pre-testing which we feel is preferable to pretesting each module of training. We will compile a complete pretest from current tests and new questions which will address every competency listed in the grant - divided into sections. All Level I trainees will take the complete pretest before any training begins to avoid contamination of data by modular training which may relate to other modules. Then we will post-test each module separately and re-administer the complete test at the end of training. Compiling the complete pre-test has become a more long-term activity and will be scheduled for completion in August.
16. Delivered all completed materials with editing and format instructions to Larry Leslie and discussed priorities of each.

APPENDIX D

1. Dissemination and Marketing Activities List

DISSEMINATION AND MARKETING ACTIVITIES

The following is a complete listing of publications, multi-media materials, presentations, workshops, and dissemination booklets prepared, developed, or presented by the Model Vision Project in the three years of operation.

Publications

The publications relating to the Model Vision Project, many of which originate from the Diagnostic Component are listed below.

- Bourgeault, S. E., Venn, J. J., Harley, R. K., & DuBose, R. F. The model vision project -- Part I: A conceptual framework for service delivery. Journal of Blindness and Visual Impairment, January, 1977.
- Bourgeault, S. E., Venn, J. J., Harley, R. K., & DuBose, R. F. The model vision project -- Part III: Field services. Journal of Blindness and Visual Impairment, March, 1977.
- DuBose, R. F. Developmental needs in blind infants. The New Outlook for the Blind, Spring, 1976.
- DuBose, R. F., Langley, B., Bourgeault, S. E., & Harley, R. K. The model vision project: Assessment and programming for blind children with severely handicapping conditions. Journal of Blindness and Visual Impairment. February, 1977.
- DuBose, R. F. The Multiply Handicapped Child: The Diagnostician's Challenge, April, 1976. ED 122488.
- DuBose, R. F. Assessing motor skills in multiply handicapped children. April, 1976. ED 122489.
- DuBose, R. F. Assessing communication in nonverbal children. April, 1976. ED 122490.
- DuBose, R. F. Translation of assessment data into practical applications for multiply handicapped children. April, 1976. ED 122491.
- DuBose, R. F. The Predictive value of infant intelligence scales with multiply handicapped children. American Journal of Mental Deficiency, January, 1977.
- DuBose, R. F., Langley, M. B., & Stagg, V. Assessing severely handicapped children. Focus on Exceptional Children, 1977, 9, 1-13.

- DuBose, R. F., & Folio, R. Investigation of short term goals in motor skill achievement in delayed and non-delayed preschool children. Peabody Journal of Education, April, 1977.
- DuBose, R. F. Identification of the moderately, severely and profoundly handicapped. In M. E. Snell (Ed.) A Systematic Approach for Instruction of the Moderately, Severely, and Profoundly Handicapped. Columbus, Ohio: Charles E. Merrill Co., 1978.
- DuBose, R. F. Screening severely handicapped children with the Developmental Activities Screening Inventory, AAESPH Review, 1977.
- DuBose, R. F. The multiply handicapped child: The diagnostician's challenge. Accepted by Diagnostique, 1977.
- DuBose, R. F. Assessing motor skills in multiply handicapped children. Accepted by Diagnostique, 1977.
- DuBose, R. F. Development of communication in nonverbal children. Education of Training of the Mentally Retarded, 1977.
- Harley, R. K., Merbler, J. B., Corbett, M. P., Bourgeault, S. E., & DuBose, R. F. The model vision project -- Part IV: Training and evaluation. Journal of Blindness and Visual Impairment. April, 1977.
- Langley, B., & DuBose, R. F. Functional vision screening for severely handicapped children. The New Outlook for the Blind, 1976, 70(8), 346-350.
- Merbler, J. B., & Harley, R. K. Implementation of a precision teaching data collection system in the program for multiply handicapped visually impaired children. Education of the Visually Handicapped, 1977, 8, 97-102.

Multi-Media Materials

"Five Special Children Learning: A Community Effort", developed by MVP, slide/tape presentation.

Series of cassette tapes and papers prepared by Dr. Rebecca F. DuBose for the Region Service Center in Ft. Worth, Texas.

"Communication with Deaf-Blind Students"

"Communicating with Parents of Severely and Profoundly Handicapped Children"

"Assessing Language Potential in Multiply Handicapped Children"

"Establishing Goals and Objectives for Severely and Profoundly Handicapped Persons: What Can We Expect?"

"Teaching Orientation and Mobility Skills to Multihandicapped Visually Impaired", developed by Mike Corbett, Orientation and Mobility Specialist, slide/tape programmed instruction module.

Presentations at Conferences and Workshops(*denote training activities
in the MVP catchment area)

Educational Service Center	Address: "Educating Severely Handicapped Children"	August 25-26, 1975
Texas Education Agency Educational Service Center Austin, Texas	Workshop: Assessment of Severely Handicapped Children	September 22-23, 1975
* Workshop for Community Workers Tennessee Department of Mental Health, Nashville, Tennessee	Workshop: Educational Planning for the Severely Handicapped	September 26, 1975
Conference of Educating Deaf-Blind, Orlando, Florida	Workshop: Teaching the Deaf-Blind Child	October 11, 1975
Conference on Severely Handicapped, Kansas City, Missouri	Diagnostic Services for Severely Handicapped Children	November 11, 1975
Regional Child Development Center, Big Stone Gap, Virginia	Program Evaluator of Title VI-B Program	December 5-9, 1975
State of New Mexico Conference on Assessment of Severely Handicapped Albuquerque, New Mexico	Address: "Assessment of Severely Handicapped Children"	February 4-5, 1976
International Conference Council for Educational Diagnostic Services, Chicago, Illinois	Mini-Workshop: Assessing the Multihandicapped Child	April 7, 1976
International Conference Council for Exceptional Children, Chicago, Illinois	Chairperson: Translation of Assessment Data into Practical Applications	April 7, 1976

Fourth Annual International Congress on Scientific Study in Mental Retardation	Paper: "The Development Activities Screening Inventory"	August 24, 1976
Wisconsin School for the Visually Handicapped Janesville, Wisconsin	Two-day Workshop: Assessment of Severely/Profoundly Multihandicapped Blind Children	August 26-27, 1976
Hou-Met Chapter of the Council for Educational Diagnosticians, Houston, Texas	Workshop: "Assessment of Multihandicapped Children"	September 14, 1976
* Innovative Training Grant Peabody College	Workshop: MVP Programs and MVP Precision Teaching Data Collection System	September 28, 1976
North Dakota State Administrative Personnel Minot, North Dakota	Workshop: Assessment of Multihandicapped Children	
AAESPH Conference Kansas City, Missouri	Paper: Diagnostic Model of the Model Vision Project	October 10-12, 1976
AAESPH Conference Kansas City, Missouri	Paper: The Model Vision Project	October 10-12, 1976
Texas Educational Agency Austin, Texas	Paper: "Assessment/Diagnosis of Multiply Handicapped"	October 21, 1976
Dade County Public Schools Miami, Florida	Workshop: "Assessing Severely Handicapped Children"	November 18-19, 1976
Region I - Educational Service Center Edinburg, Texas	Consultation: Educational procedures for severely handicapped visually impaired	December 4-5, 1976
Region III - Educational Service Center Victoria, Texas	Workshop: Assessment of the Severely Handicapped	December 10-11, 1976
* Meharry Medical College Nashville, Tennessee	Educational Programming for the Visually Impaired Multiply Handicapped Individual	Spring, 1977

* Easter Seals, Nashville Tennessee	Consultation on Setting up a Classroom for Visually Impaired Infant-Toddler	Spring, 1977
* Department of Human Services Nashville, Tennessee	Working with the Multiply Handicapped	Spring, 1977
* Council of Community Services Nashville, Tennessee	The MVP in Middle Tennessee	Spring, 1977
* Vanderbilt Hospital	Vision Screening of the Multiply Handicapped	Spring, 1977
* Clover Bottom Developmental Center, Nashville, Tennessee	Techniques for Blind Multiply Handicapped	Spring, 1977
* Rochelle Training Center Nashville, Tennessee	Orientation and Mobility	Spring, 1977
* Metro Board of Education Vocational Advancement Program	MVP and VAP	Spring, 1977
Mississippi School for the Blind	Consultation on Evaluation of Blind Adolescents	Spring, 1977
Virginia Commission for the Blind	Consultation on Programming Classroom Arrangement, Behavior Management for the Totally Blind	Spring, 1977
* Outlook Nashville, Nashville, Tennessee	Educational Programming for the Visually Impaired, Multiply Handicapped Individual	Spring, 1977
* Vanderbilt Cerebral Palsy Clinic Nashville, Tennessee	Consultation on Cognitive Development	Spring, 1977
* Metropolitan Itinerant Vision Teachers, Nashville, Tennessee	Workshop: Visual Screening of Preschool Child through High School Age.	Spring, 1977

* Southeast Regional Association for Retarded Citizens Nashville, Tennessee	Assessment of Severely Handicapped Child	Spring, 1977
Parent Information Exchange Conference of Southeast Regional Deaf-Blind Center, Atlanta, Georgia	Special Parents, Special Education, and Very Special Children	May, 1977
Center for Children with Learning Disorders, University of Alabama, Birmingham, Alabama	Assessing Severely Handicapped Persons	June, 1977
AAMD New Orleans, Louisiana	Informal Assessment of Severely Handicapped Persons	June, 1977
AAMD New Orleans, Louisiana	Translation of Educational Prescriptions into Daily Lesson Plans	June, 1977
Galluadet College Washington, D.C.	Workshop: Cognitive and Language Development in Deaf-Blind Children	June, 1977
* General Hospital Nashville, Tennessee	Workshop: Influence of Blindness on Development; Visual Screening of Low Functioning Children; Talking to Parents	June, 1977
AAESPH Conference San Francisco, California	Papers: Model Vision Project	October, 1977
Developmental Evaluation Center Western Carolina University	Developmental Evaluation and Programming for Young Multihandicapped	October 4, 1977
* George Peabody College Class: Sensory Perception and the Anatomy, Physiology and Hygiene of the Eye	Vision Training for the Low Vision/Low Functioning Child	October 13, 1977
* Project S.E.R.V.E. Peabody College	Development of the Handicapped Child and Individualized Educational Programming	October 22, 1977
Chattanooga, TN United Cerebral Palsy	Development in Handicapped Children	October 28, 1977

Deaf/Blind Training Program University of Hawaii	Inservice Training Workshop	November, 1977
* Project S.E.R.V.E. Peabody College	Intervention Strategies Curriculum	November 1, 1977
* George Peabody College Class: Introduction to Special Education	The Model Vision Project	November 1, 1977
Alexandria, VA Preschool Diagnostic Center	Evaluation and Programming of Multihandicapped Children	November 10-11, 1977
* Metro School Psychologists Nashville, Tennessee	Assessment Techniques with Severely Handicapped	November 17, 1977
* Project S.E.R.V.E.	Assessment Techniques with Severely Handicapped	November 17, 1977
* Crockett Academy Nashville, Tennessee	Problems Encountered in the Education of the Blind/Visually Impaired	November 21, 1977
	Orientation and Mobility	December 16, 1977
Project S.E.R.V.E.	Techniques and Suggestions for Teaching Self-Help Skills	December 3, 1977
Education Service Center Victoria, Texas	Developmental Assess- ment and Programming	January 16-17, 1978
* Shelbyville Child Development Center Shelbyville, TN	Developmental Assess- ment and Programming Methods and Materials for Teaching Young Multihandicapped Children	February 9, 1978

* Tenn. Services
for the Blind
Regional Workers
Nashville, Tenn.

-Implications of Blind-February 17, 1978
ness
-Pre-voc Beginnings for
Young Children
-Vision Screening
and Training
-How Sensory Input Affects
Cognitive Development
-Providing Opportunities
for Babies to Learn

Tennessee Behavior
Therapy Association

Generalization of February 28, 1978
Teacher-prompted
Social Behavior

Institute of
Educational Research
San Francisco, CA

Assessing Multi- February 27-28,
handicapped Children 1978

* Middle Tennessee
State University
Murfreesboro, TN

The Developmental March 1, 1978
Activities Screening
Inventory

Ellisville State School
Ellisville, Mississippi

Developmental Assess- March 30-31,
ment of the 1978
Handicapped

* Project S.E.R.V.E.
Peabody College
Nashville, TN

Workshop: Working April 1, 1978
with Parents and
families of
Visually Impaired
Multihandicapped
Preschoolers in a
Classroom Setting

State of Virginia
Petersburg State
Training School
Petersburg, VA

Workshop: Assessment April 7, 1978
and Training of the
Deaf-Blind Child

University of Tennessee
at Nashville
Conference on Visually
Impaired
Atlanta, GA

Presentation: Assess- April 8, 1978
ment of the Multiply
Handicapped

Nebraska Conference on
Severely Handicapped
Cozad, Nebraska

Presentation: Assess- April 12-14, 1978
ment of Severely
Handicapped Deaf-Blind

Institute on Trends and
Issues Concerning
Deaf-Blind Children
Des Plaines, Illinois

Committee Discussion April 14-15, 1978
Leader: Major Goals
and Objectives to be
Included in the I.E.P.

Tennessee Dept. of Public Health Knoxville, TN	Workshop: -Sensorimotor Develop- ment -Vision Screening	April 14, 1978
State of North Carolina Dept. of Visually Impaired Governor Moorehead School for the Blind Raleigh, N.C.	Workshop: -Developmental Assess- ment and Programming -Effects of Vision on Learning -Vision Screening and Training	April 20-21, 1978
* Impact Inc. Columbia, TN	Workshop: -Assessment and Program Planning to Meet Training Needs -Parent and Guardian Counseling -Linking Community Resources	April 21, 1978
Tennessee Dept. of Public Health Johnson City, TN	Workshop: -Sensorimotor Development -Effects of Primitive Reflexes on Motor Development -Teaching Parents to Provide Opportunities for Their Babies to Learn -Self-Help, Self-Care	May 5, 1978
* King's Daughters School Columbia, TN	Workshop: Prevocational Training of the Multi- handicapped Visually Impaired	May 5, 1978
New Mexico Public Schools Ratone, New Mexico	Workshop: Assessment of Severely Handicapped/ Deaf-Blind	May 18-19, 1978
St. Joseph's Hospital Scranton, Pennsylvania	Workshop: Assessment and Instruction of Visually Impaired	May 23, 1978
Westar/Model Preschool Center for Handicapped Children Conference on Infant Assessment and Interven- tion Seattle, Washington	Committee Leader: Visually Impaired Infants	June 1-2, 1978

* Tennessee Dept. of Mental Health and Mental Retardation Community Services and Handicapped Gallatin, TN	Workshop: Counseling with Parents of Handicapped Individuals	June 2, 1978
State of Florida School for the Blind St. Augustine, Fla.	Parent-Child Workshop for Deaf-Blind	June 7-9, 1978
International Council for Education of the Visually Handicapped, Council of Presidents Meeting Hanover, West Germany	Consultation: Multihandicapped, severely handicapped, visually handicapped	June 12, 1978
Regional Education Center El Paso, Texas	Consultation and Program Evaluation	June 15, 1978
Statewide Conference for Teachers of Deaf-Blind Atlanta, GA	Presentation: Effects of Vision on Learning	June 15, 1978
Statewide Meeting for Parents of Deaf-Blind Mississippi	Presentations: -What parents need to communicate to psychologists and ophthalmologists -Helping your child develop self-help skills	June 16-17, 1978
* Houston County Public Schools Erin, Tennessee	Consultation: Developing Educational Program for Multihandicapped Visually Impaired Youth	June 19, 1978
* Clover Bottom Developmental Center Donelson, TN	Workshop: Programming for Severely Handicapped Children	June 19-20, 1978
* Heads Up Day Care Center Nashville, TN	Curriculum Planning and Implementation for the Visually Impaired Multihandicapped Preschooler	June 23, 1978
International Congress on Special Education Sterling, Scotland	Presentation: Assessment of Non-verbal Children	June 23-30, 1978
* Peabody Class: Sensory Perception, and the Anatomy, Physiology, and Hygiene of the Eye	Mini-workshop: Vision Screening and Training	June 27, 1978

National Convention of
the Association for the
Education of Visually
Handicapped
Dallas, Texas

Presentation: Past
Accomplishments and
Future Plans of Model
Vision Project

June 27, 1978

National Convention of the
Association for the Educa-
tion of the Visually
Handicapped
Dallas, Texas

Assessment Panelist:
Developmental
Approach

June 28, 1978

Southeastern Region
Deaf/Blind Center
Biloxi, Mississippi

Committee Member:
Define Comprehensive
Family Services and
Design Evaluation
Process for Service
Delivery

June 29-30, 1978

MVP Booklets

- 1) Assessment of Multihandicapped Visually Impaired Children
- 2) Readings in Orientation and Mobility for Severely and Profoundly Handicapped Children with Visual Impairment
- * 3) A Guide to Orientation and Mobility for Preschool Level Multihandicapped Visually Impaired
- 4) Functional Vision Assessment
- 5) Parent Involvement
- 6) Working with Parents of Visually Impaired Multihandicapped Infants in a Classroom Setting
- 7) A Guide to Developing a Curriculum for Visually Impaired Multihandicapped Infants
- * 8) Child Development and the Effects of Handicapping Conditions on Development
- 9) A Model Field Service Delivery System: The Public Day School Component of the Model Vision Project
- *10) Prevocational Training for the Multihandicapped Visually Impaired
- *11) Instructional Materials and Suggested Activities for Multihandicapped Visually Impaired

* In editing stages.

APPENDIX E

1. Recreation and Leisure Time Activities
2. Basic Philosophy of Recreation for Severely and Profoundly Handicapped Visually Impaired Children
3. Prescription for Development of Prevocational Skills, taken from Educational Assessment
4. Skills Necessary for Success in Vocational Setting

In seeking new leisure and recreational activities for your child, there are five main objectives to be met:

1. **Safety.** Be sure the activity is safe. If possible, try it yourself first.
2. **Ability.** It must be an activity the child can do or learn to do, but don't underestimate his potential!
3. **Enjoyment.** The activity must be pleasurable or enjoyable to the child. Remember, activities that are ordinary for us can be enjoyable for a child.
4. **Physical Activity.** Modify the activity or select new ones to provide a range of physical movement for the child.
5. **Stimulation.** Be sure to arrange for and emphasize the use of his senses of touch, hearing, vision, smell, and taste. Remember, it has been proven that the use of remaining vision can be improved and in no way "uses up" his sight.

Encourage him to learn about the "sameness" and "differentness" of objects. Point these out, but don't press him. Remember, the idea is to have fun.

There are two major areas in which to have fun: in and around the home; and away in the community.

First, activities around the home.

1. It is important for your child to be involved with other children where possible. Even being in the presence of other children has beneficial effects. Place him where other children are playing. Let him play a place in board games and other games even if another child has to make his moves for him.
2. Children are natural explorers, and derive much benefit as well as satisfaction from this. Provide opportunities for exploration and handling of objects. Encourage it. He needs to find out about the world around him.
3. Mealtimes are an excellent opportunity for exploration and enjoyment. Let him try different foods, feel the texture of food with his hands, identify foods by smell, taste, and sight. Small pieces of fruits and small samples of fruit juices provide varied and enjoyable experiences.
4. Musical instruments such as a xylophone, drum, and various cranking and whirling toys that play tunes are fun. The key is to find a toy or instrument that results in a sound only when the child does something to make the sound. More advanced children may be able to keep rhythm to simple records with claps or by drumming or beating on something.

5. Table activities can all be enjoyable. Finger painting, drawing, tracing, gluing bits of colored paper to a sheet of paper, water coloring, cutting paper, play dough, modeling clay, tinker toys, stacking blocks, sorting, etc.
6. Following is a list of ordinary household items your child can have fun with. Use your imagination.

cardboard box (large or small)
 clothes pins
 scraps of material
 wooden thread spools
 paper bags
 wrapping or packaging paper (Christmas is especially good)
 blankets, sheets
 pillow
 old pots and pans
 empty cereal and other boxes
 assorted buttons
 elastic or rubber bands
 egg cartons
 empty plastic bottles and containers
 newspapers
 tin cans (with sharp edges removed)
 plastic container with beans in it
 old articles of clothing
 string
 plastic margarine tubs, coffee cans
 aluminum pie pans
 styrofoam packaging materials
 cups, spoons
 paper tower tubes

You can, no doubt, think of many items to add to this list.

7. Toys are one of the best parts of childhood. When purchasing a toy, be aware of the color of the background against which the child will most often see it. You want as much contrast as possible. A green ball on a green living room rug, for example, would be hard to see. Be aware of the different textures and shapes in the toy, its weight and size. (Is it a bit too large or heavy to manage?), small parts that could come off and be swallowed or cause injury, and the sound it produces (it should) when activated by the child. Choose toys that require the child to manipulate it rather than wind-up or battery-powered toys. When shopping for a toy take your child with you. Let him play with several and pick the one he likes. Again, you can probably add many toys to the ones on this list.

balls of various sizes and textures
 stuffed animals
 tinker toys
 shape-o ball (tupperware)
 jack-in-the-box
 crank type musical toys
 blow up punching bag
 puzzles (no more than 10 pieces, the fewer the better in the beginning)
 building blocks
 rubber squeak toys
 sound producing push and pull toys
 blow up air mattress
 wagon
 swing
 drum
 xylophone
 rattle
 peg board
 stringing beads
 crawl through tunnel
 balloons
 hanging toys
 foam toys

8. **Balls.** Balls of various sorts are probably the basic item of play throughout the world, and teaching your child ball play will add many skills to his repertoire, enabling him to play with and have fun with just about any other child. Get plenty of balls of various sizes and textures. Be alert for sound making balls that rattle, jingle or play music. Brightly colored balls will help him use his remaining vision, and will not hurt his eyes. Be careful with foam rubber balls as pieces can be bitten off and ingested.

With many of the blow-up type balls, beans, peas, BB shot, or unpopped popcorn can be put inside before inflating. The resulting sound will help him locate the rolling ball more easily. Don't over do it, though. Ten or twelve beans, peas or whatever will be sufficient, unless the ball has a very thick cover.

A small beach ball with some popcorn inside is an excellent way to begin learning to catch. Children are usually not afraid to be hit in the face with something as light as a beach ball. A tether ball adjusted to hit the tummy if he misses is good for independent play. Be content to play rolling the ball back and forth for some time before progressing to catch. Your imagination is the limit in creating play and games with balls.

9. **Water Play.** As with balls, this play may take place inside the home or outside. Bath time is an excellent opportunity for a few minutes play before, and possible after, getting down to the business of

bathing. Select a few floating toys that approximate the real object they imitate as closely as possible or something that the knowledge of which would be useful to the child. For example, a rubber blow-up ducky may look just like a ducky to us, but to the child, it is just a floating thingamajig. However, a small, ring, ball, doll, (for boys too), or cup all involve principles and concepts that are valuable as well as fun.

A bit of bubble bath or a cap of liquid detergent added to the water will give lots of interesting suds and bubbles to play with. Just splashing water or blowing bubbles with an empty plastic bottle can be loads of fun.

Outside, there is the familiar garden hose to spray in the summer time - the wading pool - and an interesting toy called the "Slip' n Slide." Attach it to the garden hose, add a little liquid soap to the surface for easier sliding, put the child on his back or bottom and push. It's very enjoyable. Caution, never leave your child unattended around water. It always pays to be extra safe.

10. Activities around the house. Our survey revealed that some children enjoy household chores. For example, one child enjoyed pushing the vacuum cleaner around while mother vacuums. Another child enjoys sorting silverware. Another folds towels. There are any number of ordinary household activities that can be used as opportunities for entertainment. Here are a few:

- dusting furniture
- taking wrapper off bar soap
- sampling cookie and cake batter and other foods
- folding towels and other items
- carrying cleaning or other items for mother
- pulling pillows, covers and sheets off bed when change is scheduled
- emptying trash cans
- sorting silverware (no sharp knives)
- throwing things away for mother i.e., taking empty boxes, cartons, etc. to the trash can
- ringing a bell for mealtimes
- sweeping
- putting away canned goods

Don't be afraid to experiment with household chores and activities. Just allow plenty of time, expect mistakes, and be safe.

11. When the weather is nice (or maybe when it isn't, - way, when it's snowing-) take your child into the "great outdoors". This is more our natural element than indoors. Slides and swings are all fun and even the most disabled child can be tied or secured safely in a swing. Start off slowly with gentle rocking first if he's apprehensive, then increase to swinging. He will soon learn to love it.

Be sure to have different surfaces and areas for him to play in. A sandbox with spoons, cups and bowls provides a good opportunity for learning to pour and scoop. Hide things under the sand and let him look for them. Let him get dirty. This is the basic right of all children. Let him play on the grass, on the dirt, the sidewalk, at the end of the gravel driveway, in the shade near the trunk of a tree, in the fallen leaves. Sometimes you have to teach a child to play, so sit down there and play with him. This is one of the most useful things you can do for your child, and yourself as a parent.

Many of the games you play indoors can also be played outdoors, especially ball games.

12. Put a picnic table or other table and chairs outside. Mealtimes outdoors can be very pleasurable for child and parent alike, and if a little food gets spilled or dropped, so what. It's a good time to practice eating skills and have a good time. Also, don't overlook the ice cream truck when it comes by on warm summer afternoons.
13. Going for a hike or walk around the yard or down the street provides a chance to examine fences, bushes, leaves, cars, signs, mailboxes and so forth. Talk about the kind of surface you are walking on, the sounds around you, and where they are coming from, the warmth of the sun, the coolness of shade trees, smells, the sound and feel of the wind blowing. If he can walk independently and there are other children, take along a small transistor radio. Give it to a child to stay ahead of you. Call attention to the children's voices and the sound of the radio ahead.
14. Of course, there is the plethora of usual summer time activities; boating, swimming, picnics, fishing, camping, and vacations. One child in our survey loves to sit in very shallow water and search for rocks under the water. If everybody is going around barefoot, take his shoes off too. Help him look like part of the group.
15. Small kiddie pools or wading pools placed out in the yard can provide hours of fun. Be careful about over-exposure to the sun, and do not leave him alone for any length of time in or around water.
16. Take your child shopping with you. Grocery shopping can easily be accomplished by allowing him to hold the bar at the rear of the basket while you guide from the front. The produce aisle is an interesting place to investigate.
17. Investigate at your church to see if there is a group your child could be placed with. Church activities such as cook-outs, camping trips, song festivities, etc., should also be taken advantage of. Talk to other parents of handicapped children in the area about including these children as a group in church activities. Then go see the minister.

18. Check with local service organizations such as the Kiwanis, Easter Seal Society and others. Some offer free tickets to community events, others summer camps, trips, etc.
19. Your local chamber of commerce, community or service organization may be aware of merchants which sponsor activities for children, for example, the local McDonald's Restaurant chain sponsors an easter egg hunt each year for handicapped children.
20. Find out where all the local parks are in your area. Familiarize yourself with their resources and programs.
21. Find out if your city or town has a parks or recreation department. These may have programs for the handicapped or may be persuaded to begin such a program. Again, a parent group is helpful. If that doesn't work out, ask specifically what activities are offered. Decide which of them your child can do, or learn to do. Then enter him. Remember, you make the decision to enter him or not, based on their advice and information. They have no right to exclude your child.
22. Survey local amusement parks. One mother who has a severely disabled child takes him on boat rides, merry-go-round, or train. She either rides with him, or when necessary, such as the boat ride for small children, walks around the ride holding him in position. It may be best to visit at other than the busiest hours. Don't worry about people watching you. They are curious about how things are done with a disabled child and are pleased to see a parent helping her child. Wouldn't you be? Talk to bystanders. They're friendly and often helpful.

Some parents have expressed an interest in taking their child to Opryland, or similar entertainment parks such as Six Flags over Georgia and others. Why not? Just make good provisions for a lot of walking and again, go at a time when it isn't too crowded.

23. Back to mealtimes again. Dining out is popular and experts predict we'll be eating more and more of our meals away from home. Fast food restaurants are economical and fun. Try different ones to find which he likes best. Some have outdoor dining facilities.
24. There should be a special olympics program in your area. Contact local schools, colleges and community groups to locate the program. There is something for practically every child in the Special Olympics.
25. If placed close enough to the T.V. or drive-in movie, many children can find enjoyment. The drive-in movie experience alone, with the family, popcorn, lights and sounds can be an enjoyable excursion.
26. One of the most stimulating experiences you can arrange for your child is a pet that can be handled such as a puppy or a kitten. Puppies are more social creatures than kittens and would probably interact with your child more. However, kittens can often be obtained already litter-trained, so take your choice.

27. Some children enjoy planting and tending a small garden of vegetables or flowers.
28. If you live far from a city, churches, schools, and civic groups may offer ideas and resources for leisure and recreation in your community. The first step is to make contact by phone or personal contact with several people in your community.
29. Your child may be eligible for a talking radio receiver. The receiver is pre-timed to a radio station that broadcasts stories, newspaper items and other information of interest to blind people. Contact your local office of services for the blind or Library for the Blind for more information.
30. Give serious thought to forming or becoming a member of a parent group. Such groups are often a great force in determining the nature of and availability of services for handicapped children.

You should find several activities on the list that your child can do. The essential thing is for you to begin investigating the resources in your home and outside it. To assist you in your search, a list of various community resources is attached.

References suggested for your reading:

"Home Stimulation"
"Exploring Materials"

Both of these publications are available from Commonwealth Mental Health Foundation, 4 Marlboro Road, Lexington, Mass. 02173.

As educators we are concerned with developing the abilities of children to their highest potential. One of these abilities which often receives too little emphasis in our educational systems is the capacity for recreational enjoyment. This is a sad note that one of the strongest motivating forces which is also of much overall physical benefit loses out in the competition with academic pursuits. One could ponder the relationship of diabetes, overweight, heart disease to our lack of sufficient activity as a nation and wonder--are we leading our children down the same path we are treading?

Even a cursory examination of this question reveals the answer to be a decided yes.

Activity is good and necessary for the well being of humans--particularly our special population. There are several advantages to a recreation program:

1. Enhancement of the range and variety of experiences and stimulations available to children.
2. Greater community awareness of the existence of special children.
3. Increased community participation as communities and agencies develop alternatives, modifications, and additions to existing programs.
4. Increased physical abilities skills, improvement in general health, and in capacity and endurance of the cardio-pulmonary system.
5. Development of meaningful and worthwhile opportunities for parent/child interaction.
6. Development of a repertoire of skills by agency and direct care personnel for working with this population.
7. Delineation of activities and requisite skills for children with varying handicaps.
8. Familiarization of parents with recreational opportunities available within the community.
9. Addition to a full range of services from agencies, schools and institutions of recreational opportunities within a community which may be offered to children.
10. Integration of special children with normal counterparts, developing social and peer interactive behaviors.
11. Collection of a list of teacher or parent made materials and plans for recreational activities.
12. Identification of recreational, resources which may be of therapeutic benefit for certain children.

Relationship of Recreation to the Professional Teacher, Agency or Institutional Worker

Educators are well aware that seldom, if ever, do you teach just one thing to a child. In learning to use his body in recreational pursuits,

he is experiencing the range of capabilities inherent in his body, experiencing new sensory data, and employing concepts of position relationship, learning new names, words and movements and incorporating these things into his sensory motor schema for use with other educational pursuits. His attentive behaviors and abilities to follow directions are enhanced. Evidence indicates an overall across-the-board improvement in school work for children engaged in a recreation/motor program.

Parameters of Recreation Project

1. It will be the purposes of the project to develop and apprise parents and agency personnel of recreational opportunities for their child in their community along with those that may be developed through other means.
 2. Delineate skills necessary for each activity with training procedures which may be used at home.
 3. Describe fully admission requirements, fees, if any, times, places, availability of transportation, and the nature of each activity.
 4. Describe enabling procedures for agencies to begin implementation of a recreational community involved program.
 5. Articulate with national organizations interested in recreational opportunities for the handicapped, such as Easter Seal Society, AAPHER, AFB, and etc.
 6. Develop a dual recreation program one for mobile children who have some awareness of people and their environment, and another program emphasizing activities for children who are less mobile and/or exhibit little awareness of people or their environment. Children who are between these two categories will begin in the higher awareness group. Likewise, activities in the lower awareness group will be geared to moving into the higher awareness group.
 7. Identify a population of varying disabilities (N=10 or greater) as a demonstration project for the activation of recreational activities identified. This will include parents and appropriate personnel from agencies, schools, etc., so that activities may be carried on by these people after the projects termination.
- ...age range for these children may be from 5 to 22 including all children in the dual program.
- ...time span for the project will be from July 1 to 31, with parents and agencies taking over from July 31, on.
- ...place: The Harris Hillman School Gymnasium and playground will be used for intensive work with low aware children, however this is subject to approval by Mr. Robert Halpin, Principal. Metro Parks Playgrounds can also be used. High aware children can participate in many of the activities planned for the summer by Metro Parks Dept. There are other activities such as bowling, swimming, and skating

available and full cooperation has been assured.

...costs will include the coordinator's salary for one month, \$1200.00, and for various fees such as rental, admission, etc., it is estimated \$100.00.

...transportation: This is usually a problem with various kinds of programs and is expected it will be here also. Efforts will be made to identify and draw on community activities which provide transportation. As mentioned, Cloverbottom residents will be bussed with no problem. Children living at home will be transported by parents who will also participate in activities. It may be possible to form car pool type services.

...a survey of MVP project parents will be initiated on the types of activities desired, activities children seem to enjoy, and willingness to assist and cooperate in the recreation project.

...activities of children and parents will be monitored through telephone and personal consultation. Alternative activities will be provided as necessary.

...renewal and update: As activities for MVP population develop and change, as more children become known, there will be a need for informing parents and agencies--a communications instrument, if you will. This can be accomplished in these ways.

1. A community agency conduct a periodic mailing to parents and teachers.
2. Articulation with national organizations interested in recreation for the handicapped. These organizations would in turn communicate with local organizations whose concerns are recreation and opportunities for children.
3. Creation of parents coalitions whose aims would be to develop and expand recreational opportunities for the handicapped.

PREScription FOR DEVELOPMENT OF PREVOCATIONAL SKILLS,
taken from Educational Assessment

Pre-Vocational Activities

Goal: Heather will independently complete prevocational tasks.

Objective: Given 8 large and 8 small washers, Heather will apply them to hooks on a board.

Procedure:

1. Construct a hookboard from a 12" x 12" piece of plywood and four rows of four cuphooks each, 8 small hooks, and 8 large hooks randomly placed.
2. Provide Heather with a jar of the washers.
3. Guide her to grasp a washer between her thumb and forefinger.
4. Guide her at her wrist to hang the washers on the hooks.
5. When she picks up a small washer, tell her, "Heather, that's a small one can you find a small hook?" Let her explore the board. If she hangs the washer on a small hook, say "that's right, Heather, you found a small hook."
6. If she selects a large hook, simply verbally prompt her to "Look for a small hook" and then physically prompt her if she doesn't look for another hook.

7. Proceed similarly for large washers.
8. Once she has applied all the washers, have her remove them and place in the jar.
9. Later you can vary this activity to simulate packaging tasks.
 - a. Provide her with many washers and two containers.
 - b. Have her sort the big and small washers into the two containers as she removes them.
 - c. A third modification is to have her fill the hookboard, then remove the washers and package them in a paper or plastic bag. She then refills the board and continues to package until all have been used.

Objective: Given 10 objects and 10 containers which can be put together (nesting kegs, aspirin bottles, jars and lids) Heather will assemble a product ten times.

Procedure:

1. Separate the parts of the containers and position them parallel to each other in vertical directions.
2. Place a container of small objects such as macaroni, pennies, bells, bolts, etc. beside the first vertical row of container parts.
3. Have Heather grasp one of the small objects, place it in one part of the container and then to cover the container or to seal it (place lid on, cover box, twist kegs together).
4. Once the container is together she can shake it to produce a noise.
5. Have her drop the completed object into a box.

Objective: Given clothespins and a box with sandpaper strips, Heather will package ten clothespins at a time.

Procedure:

1. Glue five strips of sandpaper $2\frac{1}{2} \times 3\frac{3}{4}$ " to each side of the shoebox with approximately an inch or more of space between each strip.
2. Give her a container of clothespins.
3. Have her match the clothespins, one to each sandpaper strip.
4. Teach her to feel to see if there are any strips without a clothespin.

5. Once she fills all the strips have her remove that set of clothespins and package them in a paper or plastic bag.
6. Have her continue to match in one-to-one correspondence until all the clothespins have been packaged.

Objective: Given ten sets of bolts, washers and nuts, Heather will sort and then assemble the pieces.

Procedure:

1. Give Heather a container of all the unassembled parts.
2. Place in a horizontal row before her three paper plates.
3. Have her sort the remaining pieces into the appropriate containers.
4. Guide her to place a bolt in the first plate, a washer in the second, and a nut in the third.
5. Have her pick up the bolt and turn it so that the threaded end is upright.
6. Guide her to pick up a washer and thread it onto the bolt.
7. Have her next thread the nut onto the bolt and twist until it is tight.
8. Provide a box into which she can place the completed assembly.

Objective: Given ten index cards and ten large envelopes, Heather will stuff each envelope with one index card.

Procedure:

1. Place one envelope in her hands. Guide her to lift the flap with one hand (left) and to then insert her right hand into the envelope to examine it.
2. Place the stack of index cards on her right and the envelopes on her left.
3. Guide her to lift the first envelope from the stack and place it horizontally in the middle of the table.
4. Have her lift the flap with her left hand.
5. Guide her to take an index card from the stack with her right hand and place it inside the envelope.
6. Have her fold the flap over.
7. Guide her to place the stuffed envelope in a shoebox.

Objective: Given containers of various sizes, Heather will fill each within $\frac{1}{4}$ to 1 inch from the top with common household substances 90% of the time.

Procedure:

1. Collect old sugar containers and salt and pepper shakers (like those found in cafeterias) or medium-sized prescription bottles and large jars.
2. Let her twist off the lids over an empty container to catch the residue left inside.
3. Have her place the bottles in a horizontal row with the lid to each beside the bottle.
4. Give her a plastic pitcher filled with rice.
5. Have her crook her index finger at the first joint over the edge of the jar so that the first section of the finger is inside the jar.
6. Verbally command her to fill the bottles.
7. Place your hands over hers, one on her index finger and the other over the hand holding the pitcher.
8. Guide her to continue pouring until the rice touches her index finger.
9. Verbally command her to "stop!" and physically assist her to put the pitcher down.
10. Have her twist on the lid, then proceed to the next jar and repeat.
11. Fill some smaller containers $\frac{1}{4}$ full with salt and others with pepper. Fill the large containers $\frac{1}{4}$ full with sugar.
12. Pour some sugar into a large spouted container.
13. Give Heather a box of salt, show her how to open the salt and verbally prompt her to "open the salt."
14. Guide her to grasp a small container and smell. Verbally cue her that it's salt, then prompt her to fill it as in steps 5-9.
15. Give her the pepper container, show her how to open it, and tell her it's pepper as she smells.
16. Guide her to grasp a small container and fill it with pepper as in steps 5-9.

17. Continue to do the same with the sugar but have her grasp the large container.
18. Place the three containers of salt, pepper and sugar beside each other on Heather's right.
19. Put all the containers filled $\frac{1}{4}$ of the way in a shallow box.
20. Have Heather select a container, open it, smell it, then guide her to pick the appropriate condiment container and fill the jar. Also verbally label the condiment for her.
21. Guide her to return the condiment container to its place, twist on the lid to the jar, then deposit the filled container in a box beside her on the floor.
22. Continue this procedure until all jars have been correctly filled.
23. Arrange a set of drinking glasses before her. Have her fill each glass with ice cubes and then water.

Goal: To develop more independence in daily living skills.

Objective: Given pants, shirts, underwear, socks, and bras, Heather will sort them into groups and put them away in the appropriate drawer spaces with 90% accuracy.

Procedure:

1. Place all her clothing in a clothesbasket and position it near a chest of drawers and some working surface, such as a bed.
2. Have her take one of each item and place it on the bed in order from left to right (socks, panties, bra, shirt, pants).
3. Continue to have her reach into the basket, discover what the item is then group it with the others.
4. When she completes the sorting, guide her to place each group of clothes in a specific spot in the drawers.
5. Guide her to count from the top drawer to discover where the second, the third, the first drawer is. Place her hand on the first and tell her that it is the first drawer. Draw her hand down to the drawer pulls on the second drawer, then the third, always telling her which drawer she is touching.

In order to develop a realistic vocational program one must know the abilities and disabilities of the students involved, determine the fundamental skills necessary to function in competitive employment and construct a continuum of behavioral objectives which result in the student's acquisition of the skills required in a competitive employment situation. There are five major skills areas, which include those specific skills, common to all jobs, that are necessary for successful and continuing employment. These classes of behaviors are:

- A) cognitive functioning,
- B) motor coordination, including orientation and mobility,
- C) communication
- D) daily living skills, and
- E) adaptive behaviors and social skills.

The cognitive skills required may vary greatly among different types of work. The particular skills discussed in this paper are those required in the simplest type of competitive employment commonly obtainable--collating and assembly tasks. For the more advanced student, job analysis of an appropriate vocational placement will reveal other requisite cognitive skills. The fundamental skills include:

- 1) Discrimination. The student must identify, sort, and match objects. While the totally blind person must obviously rely mainly on touch, it is important for the client who does have some vision not to disregard touch as a mode for discriminating. Over-reliance on partial-vision may result in a slow work pace and difficulty with small objects.
- 2) Imitation. Clients, especially those with receptive language problems, must copy the actions of others in performing the job task. Obviously this ability facilitates the acquisition of other important behaviors such as daily living skills.
- 3) Concept of self. The client must know his name and understand the difference between his work area and materials and those of others.
- 4) One-to-one correspondence. This concept is basic to assembly tasks and is also preparation for learning to count which most jobs require.
- 5) Part-whole concept. This concept is basic to most assembly tasks.
- 6) Attending to task. The client must continue working until all work is finished or it is time for a scheduled break. In training, the task may need to be adapted to build the attention span

slowly, or to be done in shorter time segments.

- 7) Sequencing. The client must understand the sequence of events for the job. To stuff envelopes one first folds the letter, places in the envelope, wets the glue on the flap, folds and seals. Sealing the envelope first precludes correct performance of the task.
- 8) Recognition of job completion. After correctly stuffing an envelope one does not then fold the envelope, stuff into another envelope, wet and seal ad infinitum; nor does one open the sealed envelope, unfold and refold the letter, stuff and seal again.
- 9) Retention. After training employers expect a client to remember the job from one day to the next, over weekends, or over brief absences due to illness without needing re-orientation.
- 10) Generalization and transfer. An employee who assembles kits of assorted screws should not require complete retraining to assemble kits of assorted nails. Moving the work station should not seriously interrupt his or her production at the same job.
- 11) Self-initiating. The client must begin work in the morning and after breaks without prompting from a supervisor.
- 12) Problem solving. This includes recognition of problems, attempting to find solutions independently, and seeking help when the worker cannot solve the problem quickly enough to prevent interrupting production.
- 13) Concept of personal safety.

For multihandicapped visually impaired persons orientation and mobility is an integral part of overall motor functioning. The vocational trainer and/or classroom teacher should introduce activities to develop these skills very early in a child's educational program. Motor skills critical to positive vocational placement are:

- 1) Fine motor coordination sufficient to grasp and hold using thumb opposed and four fingers, and pincer grasp and hold.
- 2) Gross motor skills - primarily purposeful ambulation with or without mechanical aids and the ability to maintain a sitting or standing position for extended periods of time.
- 3) Orientation and mobility has been found to be the most outstanding difference between "successful" and "unsuccessful" placements. The employee must be able to get around a familiar job site independently, through use of the sighted guide technique, or use of a cane in an unfamiliar setting.

The worker must be able to "wait" upon request.

Communication skills may not necessarily include speech although clients without understandable speech will find employment considerably more difficult to obtain. Minimal communication for vocational purposes consists of:

- 1) Receptive language. The employee must understand job instructions. The vocational trainer may provide extra instruction for clients with limited receptive vocabularies by providing models for imitation. The client must also recognize "survival" words such as "no", "stop", "good", "come here", etc.
- 2) Expressive language. The worker must communicate important needs such as "bathroom", "help", "hurt" through words, signs, or gestures.

The list of daily living skills has purposely been pared to only those which are observable and necessary on the job. There are so many important, essential daily living skills that the wise vocational trainer will delegate as many of them as practical to the classroom teacher or the client's family. The trainer must be sure the client has mastered these skills:

- 1) Completely toilet trained. The client must self-initiate going to the restroom when necessary and perform all the component behaviors independently.
- 2) Dressing. On the job the client will be required to put on and remove weather clothes such as a coat, hat, galoshes, and safety gear including apron or gloves. The client must also keep the socially required clothing on and in order, i.e. a man may not remove his pants because he is hot.
- 3) The worker must use money as a medium of exchange, not something to throw away, lose, or hoard.
- 4) The client will need to either operate a vending machine, go through a cafeteria line or restaurant, or unwrap a bag lunch. Eating must, of course, be independently done in a socially acceptable manner.
- 5) The client must display generally acceptable hygiene, e.g. he/she should wash hands and face without being told, should wipe a runny nose or drooling lip.
- 6) There also exists a group of daily working skills specific to employment. These include regular attendance, prompt arrival and departure, and the ability to use a time clock or sign-in.

Finally a common cause for the failure of a client to obtain or retain a job is the lack of socially adaptive behaviors. Employers

often consider a pleasant personality as important as production capability.

- 1) The worker must get along with other employees. The amount of sociability required may vary greatly among job sites.
- 2) The client must not display any grossly socially unacceptable behaviors. The other men in the shop may think he's a great guy, but if he has a tantrum everytime the secretary walks by without speaking, chances are the job won't last long.
- 3) All workers need an appropriate outlet for expressing emotions, both negative and positive feelings.
- 4) The client must be flexible, able to accept or adapt to change. He must accept more than one authority figure.

Drawn from:

Model Vision Project:
A Framework for the Vocational Training of Blind,
Multiply-handicapped Clients

by:

Carol Ann Bonner

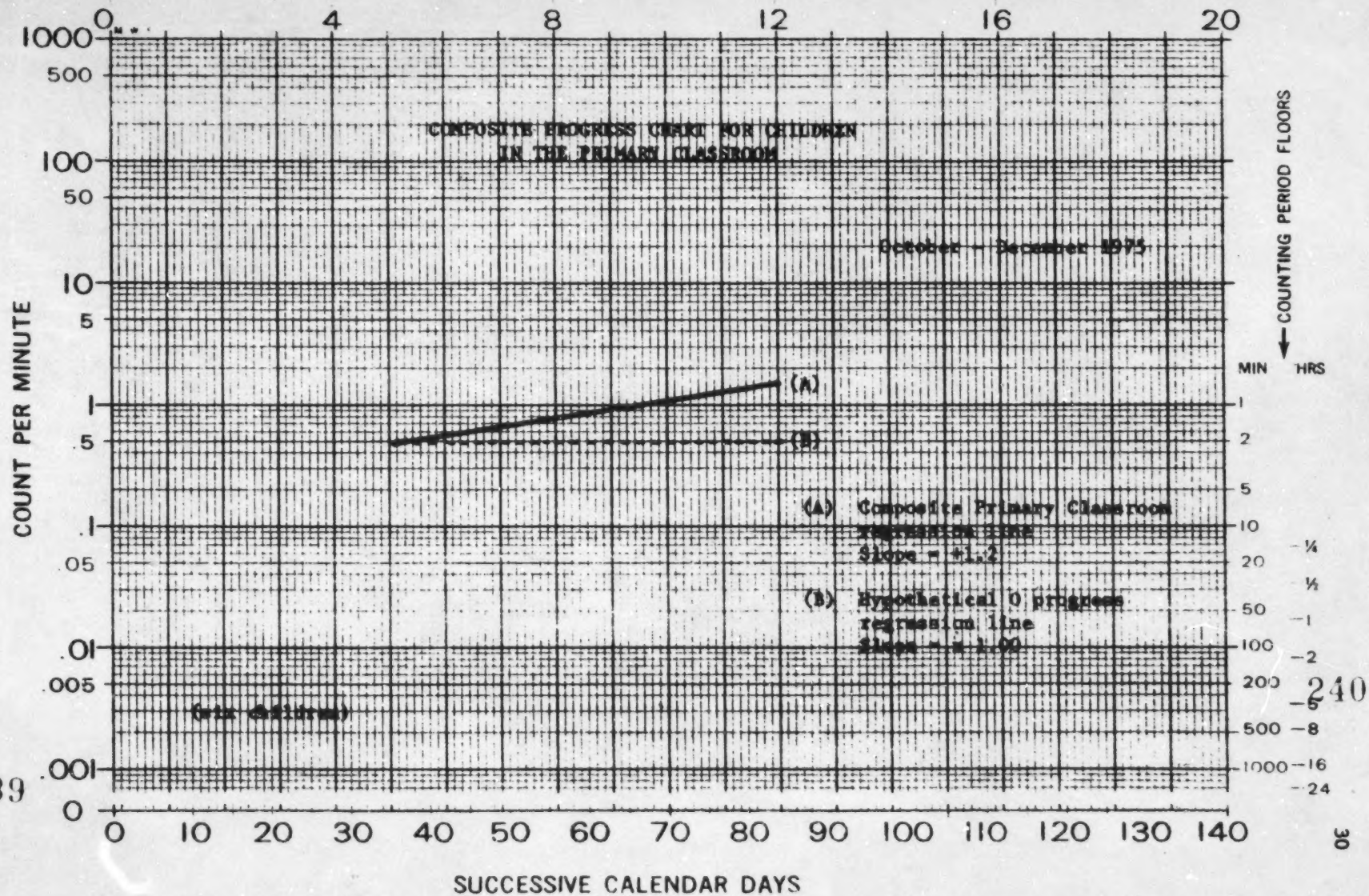
APPENDIX F

1. Composite Progress Slopes
2. Parental Telephone Survey
3. Student Progress Tracking Form
4. Decision Map: Module and
Related Material Development
5. Module Validation Tracking Form
6. Staff Time Utilization Form

CALENDAR WEEKS



6 CYCLE 100 DAYS 100 WAYS
BEHAVIOR RESEARCH CENTER
BOX 1311 SAN ANTONIO, TEXAS 78211



SUPERVISOR

ADVISER

MANAGER

BEHAVIOR

AGE

LABEL

COUNTED

DEPOSITOR

AGENCY

TIMER

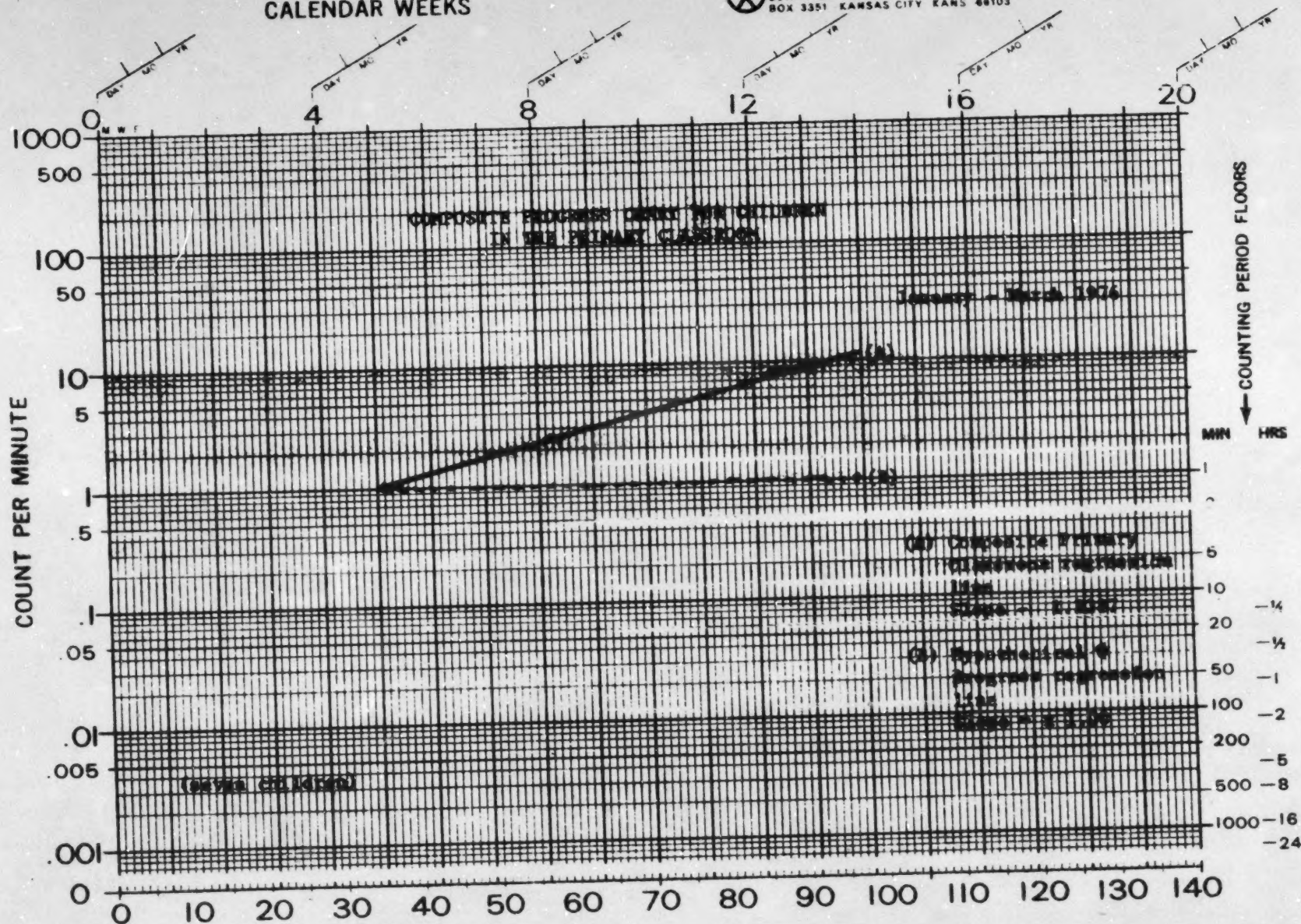
COUNTER

CHARTER



DAILY BEHAVIOR CHART (4-14)
5 CYCLE 140 DAYS (20 WKS)
BEHAVIOR RESEARCH CO
BOX 3351 KANSAS CITY KANS 68103

CALENDAR WEEKS



SUCCESSIVE CALENDAR DAYS

242

00 241
SUPERVISOR ADVISER MANAGER

BEHAVIOR AGE LABEL COUNTED

DEPOSITOR

AGENCY

TIMER

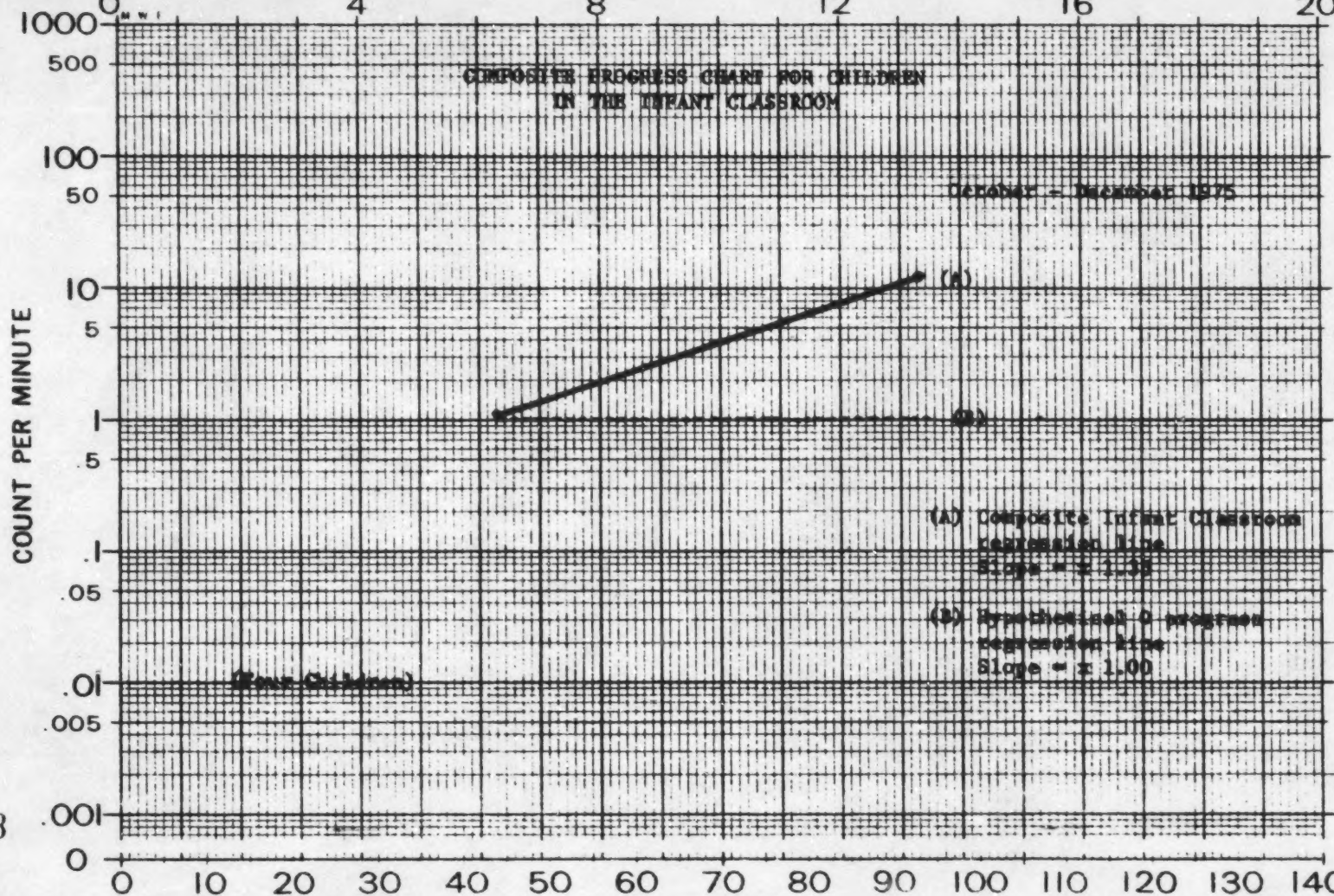
COUNTER

CHARTER

CALENDAR WEEKS



AN INSTRUMENT FOR COUNTING
A CYCLE OF 40 DAYS (20 WEEKS)
BEFORE THE REPAIR WORK
BUT NOT KANSAS DEPARTMENT OF HEALTH



SUPERVISOR

ADVISER

MANAGER

BEHAVIOR

AGE

LABEL

COUNTED

DEPOSITOR

AGENCY

TIMER

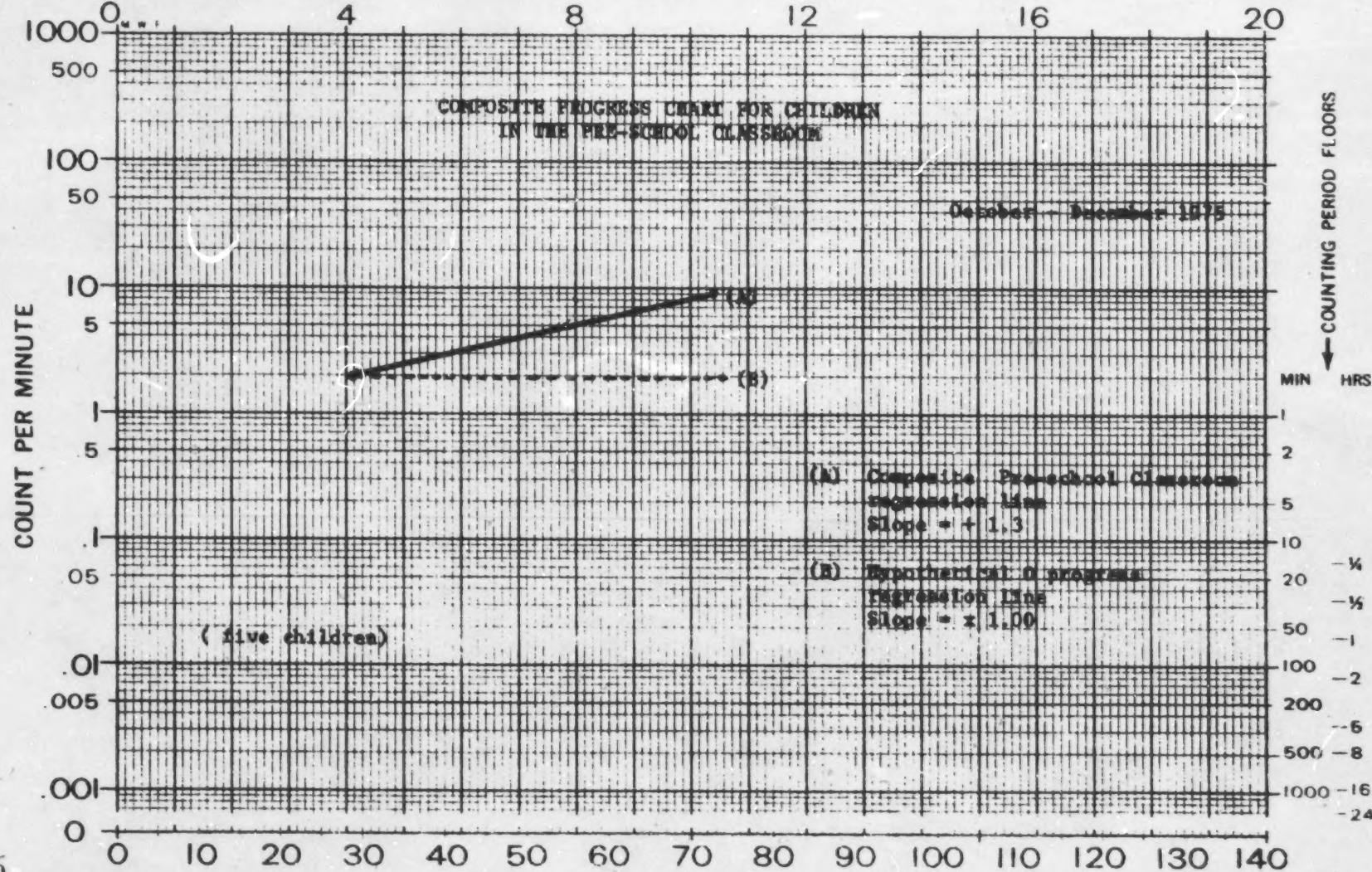
COUNTER

CHARTER

CALENDAR WEEKS



YOUTH SERVICES DIVISION
BEHAVIOR RESEARCH UNIT
201 N. 10TH AVENUE, KANSAS CITY, KANSAS 64108



SUPERVISOR ADVISER MANAGER

BEHAVIOR AGE LABEL COUNTED

DEPOSITOR

AGENCY

TIMER

COUNTER

CHARTER

246

Parental Telephone Survey

1. Has your child been evaluated
(e.g. psychological, educational
testing) since he/she was enrolled
in Model Vision Project Services?

No

Yes

- a) Do you think you have a better
understanding of your child's
strengths and weaknesses following
his/her evaluation?

1	2	3
No	Somewhat	Much better

- b) Did you receive clear, understand-
able written feedback on your child's
performance?

1	2	3
Unclear	Good	Clear and easy to understand

- c) Did the diagnostic staff answer your
questions about your child's performance?

1	2	3
No	Some	All

(Unanswered questions _____

_____)

- d) Did you receive information which will
help you work with your child at home?

1	2	3
No	Some	Very much

- e) What is your overall rating of your
child's evaluation?

1	2	3
Poor	Good	Excellent

2. Is your child presently or scheduled to be enrolled in an educational program (e.g. Harris Hillman School)?

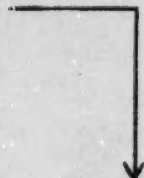
No 

Do you think your child needs these services?

No Yes



3. Have you received the services of the Model Vision Program home liaison teacher during this past year (July 1, 1976 - June, 1977)?

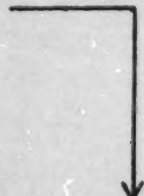
No 

Do you think you or your child needs these services?

No Yes



4. Have you received the services of the Model Vision Project social worker during the past year?

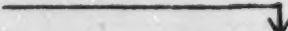
No 

Yes 

- a) How would you rate the educational services your child is receiving?

1 2 3
Poor Good Excellent

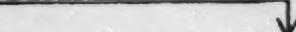
- b) How could these services be improved _____

Yes 

- a) How would you rate the home liaison services you have received?

1 2 3
Poor Good Excellent

- b) How could these services be improved?

Yes 

- a) How would you rate the social work services you have received?

1 2 3
Poor Good Excellent

Do you think
you or your
child needs
these services

No Yes

5. Have you participated in any
Model Vision Project parent train-
ing sessions or workshops?

No

Why? _____

6. Do you think your child is
receiving all of the services
he/she needs?

No

What additional
services do you
think are needed?

- b) How could these services be
improved? _____
- _____
- _____

Yes

- a) Did you receive useful information
for working with or understanding
your child?

1	2	3
Poor	Good	Excellent

- b) How could the training activities
be improved? _____
- _____
- _____

- c) What types of additional training
activities would you like?
- _____
- _____
- _____

Yes

- a) What is your overall rating of the
services your child has received?

1	2	3
Poor	Good	Excellent

WORKSHOP EVALUATION

Date: _____

Workshop _____

1. The experience was:

_____ a) worth the time spent

_____ b) too long

_____ c) too short

2. I found the content of the workshop to be:

1	2	3	4
Not useful		Useful	

3. The presentations were:

1	2	3	4
Unclear		Clear	

4. I found the organization of the workshop to be:

1	2	3	4
Disorganized		Well-organized	

5. I found the materials to be:

1	2	3	4
Unhelpful		Helpful	

6. The following aspects of the workshop were especially useful:

a.

b.

7. The following aspects of the workshop could be improved:

a.

b.

8. Do you think you were adequately prepared for the material presented?

_____ Yes _____ No If no, explain.

9. How does this workshop enhance the skills of a teacher?

10. Comments.

KEY:

- 1= 100% help 216
 2= 75% help
 3= 50% help
 4= 25% help
 5= Total Independence

STUDENT PROGRESS TRACKING FORM

Name of Student: _____ Date of Prescription: _____
 Date of Birth: _____ Teacher: _____
 Instructional Location: _____

MOTOR DEVELOPMENT: Developmental Ages: 1) Gross Motor Initial Re-Evaluation
 2) Fine Motor _____

Test Used: _____
 Long range goals: 1.
 2.

Beginning	Short term objectives as prescribed by teacher	Source	Projected Ending Date	% of Progress					Comments
				1	2	3	4	5	

LANGUAGE DEVELOPMENT: Developmental Ages: 1) Receptive Initial Re-Evaluation
 2) Expressive _____
 Test Used: _____
 Long range goals: 1)
 2)

Beginning Date	Short term objectives as prescribed by teacher	Source	Projected Ending Date	% of Progress					COMMENTS
				1	2	3	4	5	

COGNITIVE DEVELOPMENT: Developmental Age: Initial Re-Evaluation

Test Used: _____

Long range goals: 1)
2)

Beginning Date	Short term objectives as prescribed by teacher	Source	Projected Ending Date	Progress	COMMENTS

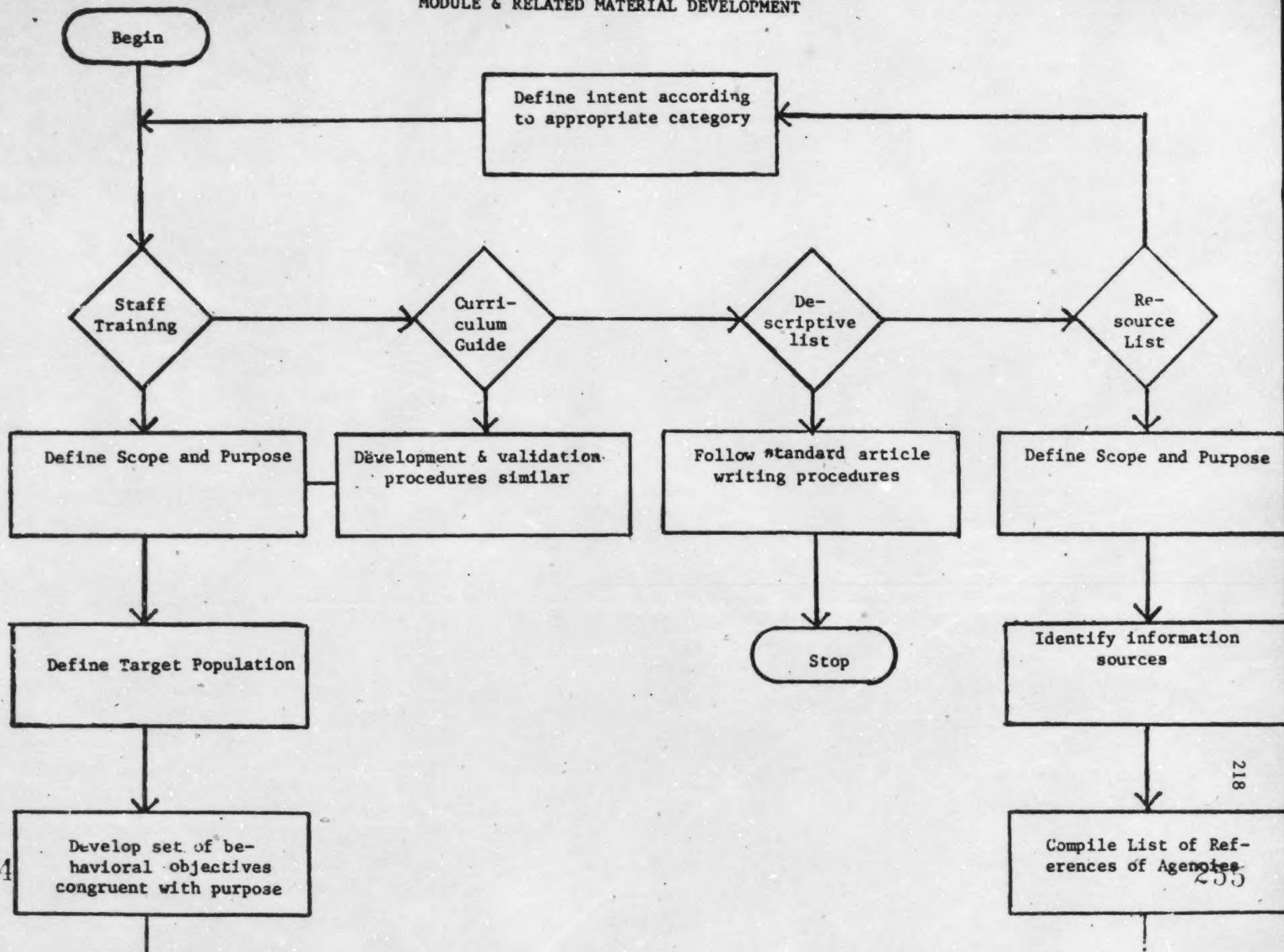
SELF CARE DEVELOPMENT: Developmental Age: Initial Re-Evaluation

Test Used: _____

Long range goals: 1)
2)

Beginning Date	Short term objectives as Prescribed by teachers	Source	Projected Ending Date	Progress	Comments

MODULE & RELATED MATERIAL DEVELOPMENT



Develop a set of performance standards for objective achievement

Select module format (ed., self study, workshop)

Select support media (e.g. slides, tape)

Write content congruent with selected objectives

Write practice exercises

Solicit expert review of module objectives & content

Write introduction & module implementation guidelines

Write criterion referenced test instrument

Revise content & objectives per expert review

Prepare prototype support media per content

Go to Validation Flow chart for validation & revision procedures

Cite source of information in appendix for list updating mechanism

Check accuracy of all list entries (e.g. addresses, phone numbers)

Stop

MODULE VALIDATION TRACKING
FORM

I. Module: _____

Date of Workshop: _____ Time required: _____

No. of sessions: _____

Participating Agency or Group: _____

Number of Participants: _____

Name of Workshop Leader(s): _____

II. Pre and Posttest Results: (Please list scores from pre- and post-
tests for each participant)

Pretest

Posttest

III. Type of Data Analysis: _____

Results of Analysis: _____

Results of Item Analysis: _____

Summary: _____

Number of Times Module Administered: _____

STAFF TIME UTILIZATION FORM

Name _____

Position _____

Month _____

	1st week	2nd week	3rd week	4th week	5th week	Total
Direct Contact						
Indirect Contact						
Preparation of Materials						
Other						
Total						

Estimate total hours spent in each category per week.

Direct Contact -- Time spent with parents and children

Indirect Contact -- Time spent with project or agency staff members in training or planning services for parents and children (e.g., in-service training for Clover Bottom Staff, Murci House Staff, etc.; planning with Harris-Hillman Teachers).

Preparation -- Time spent preparing training packets or materials for parents and children (e.g., parent training packets, planning parent meetings, etc.).

Please submit to project evaluation on the 5th of each month following recorded month.